

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

01107

CERTIFICATE OF DEATH

01107

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edmonston (Hyattsville)</b>		16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Memorial Hospital</b>				d. STREET ADDRESS <b>5104 Emerson Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>First MARY BOY Middle Last ADAMS</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>14</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-13-67</b>		9. AGE (In years last birthday) <b>0</b> yrs.	IF UNDER 1 YEAR Months <b>12</b> Days <b>17</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Prince George, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Adams, Donald L.</b>				14. MOTHER'S MAIDEN NAME <b>Williams Adams, Judith A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Donald L. Adams Same as #2 (father)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>776X IMMEDIATE CAUSE (a) Prematurity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-13</b> , 19 <b>67</b> , to <b>1/14</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1-14</b> , 19 <b>67</b> , and that death occurred at <b>9</b> AM, from causes and on the date stated above.							
22a. SIGNATURE <b>M. D. Purdie, M. D.</b>				22b. ADDRESS <b>4404 Queensbury Rd., Riverdale, Md.</b>		22c. DATE SIGNED <b>1/14/67</b>	
23a. BURIAL, CREMATION, <b>BURIAL</b> (Specify)		23b. DATE THEREOF <b>1/16/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, P.G. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 16 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01108				CERTIFICATE OF DEATH				01108			
1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Accokeek Md</b> c. LENGTH OF STAY IN 1b <b>17-Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Accokeek Md</b> d. STREET ADDRESS <b>16-1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Rada Florence Aleshire</b> First Middle Last 4. DATE OF DEATH <b>1-28-1967</b> Month Day Year						5. SEX <b>Female</b> 6. COLOR OR RACE <b>W-US</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>9-8-1903</b> 9. AGE (In years last birthday) <b>63 yrs.</b> IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Luray-Virginia</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>						13. FATHER'S NAME <b>Charles E. Turner</b> 14. MOTHER'S MAIDEN NAME <b>Lilly H. Rickard</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b> 16. SOCIAL SECURITY NO. <b>577-16-8653</b> 17. INFORMANT <b>Cecil Aleshire-Accokeek Md-Husband</b> Address						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion-Massive</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-Sclerotic Heart Disease</b> DUE TO (c) <b>Ageing Process</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						21. I certify that (I) (this hospital) attended the deceased from <b>1-1-1962</b> , to <b>1-28-67</b> , 19____, that (I) (we) last saw the deceased alive on <b>1-28-67</b> , 19____, and that death occurred at <b>5:30 AM 1-28-1967</b> 22a. SIGNATURE <b>James E. Andrews MD</b> 22b. DATE SIGNED <b>1-28-67</b> 22c. PHYSICIAN'S NAME (Type) <b>James E. Andrews MD</b> 22d. ADDRESS <b>Indian Head Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>1-30-67</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b> 23d. LOCATION (City, town or county) (State) <b>Washington D.C.</b>						24a. REC'D BY REGISTRAR <b>JAN 31 1967</b> 24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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FOR STATE  
HEALTH DEPT.

01109

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01109

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>7 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> <b>16.1</b>	
3. NAME OF DECEASED (Type or print) <b>Fred A Allen</b>		4. DATE OF DEATH Month <b>1</b> Day <b>25</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 Jan. 1918</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard "World wide detective agency"</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>	9. AGE (In years last birthday) <b>49 yrs.</b>
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Wm R. Allen</b>		14. MOTHER'S MAIDEN NAME <b>Kate Yapel</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W. W. II</b>		16. SOCIAL SECURITY NO. <b>206 09 6063</b>	
17. INFORMANT <b>Evelyn V. Allen</b>		Address <b>Hyattsville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral severe pneumonitis</b> DUE TO <b>And cerebral edema and contusion</b> (b) <b>From basalar skull fracture</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian struck by car.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>6:00pm</b> p.m. <b>1-18- 1967</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 197 &amp; Balt. Wash. Parkway, Prince Geo. Co</b>		20f. (City or town) (County) (State) <b>Prince Geo. Co</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>1-25-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>Jan 25, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Schweikert Funeral Home</b>	23d. LOCATION (City or Town) (County) (State) <b>Waterford Erie co Pa.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>JAN 30 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

01110

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

011110

CERTIFICATE OF DEATH

011110

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAPITAL HEIGHTS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAPITAL HEIGHTS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>REGENT NURSING HOME, FORESTVILLE</b>		d. STREET ADDRESS <b>403 CABIN BRANCH ROAD</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JULIA M ALSOP</b>		4. DATE OF DEATH Month Day Year <b>JANUARY 5 19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DECEMBER 24, 1892</b>
9. AGE (In years last birthday) yrs. <b>74</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>19 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>DELAWARE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>SULIVAN TIMOTHY SKKXAN</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET DUGAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HAROLD D. ALSOP</b>		Address <b>7322 LACONA ST. BERKSHIRE, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr 3 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-22, 1966</b> to <b>1-5, 1967</b> , that (I) (we) lost saw the deceased alive on <b>1-4, 1967</b> , and that death occurred at <b>7A</b> M, from causes on and on the date stated above.			
22a. SIGNATURE <b>T F Cleary</b>		22b. DATE SIGNED <b>Jan 6, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas F. Cleary M.D.</b>		22d. ADDRESS <b>3611 Branch Ave. Wash D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>JAN. 7, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>	23d. LOCATION (City or town) (County) (State) <b>PRINCE GEORGES, MARYLAND</b>
24. FUNERAL DIRECTOR <b>WILHELM FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 10 1967</b>	
ADDRESS <b>4308 SUITLAND ROAD, SUITLAND MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1944-1945

1946-1947

1948-1949

1950-1951

1952-1953

1954-1955

1956-1957

1958-1959

1960-1961

1962-1963

1964-1965

1966-1967

1968-1969

1970-1971

1972-1973

1974-1975

1976-1977

1978-1979

1980-1981

1982-1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 011111

011111

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>908-60th Ave, Fairmont Hts</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>SAME</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCE GEORGE COUNTY, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLARENCE</u> First <u>ANTHONY</u> Middle <u>ANTHONY</u> Last				4. DATE OF DEATH Month <u>1</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-27-1911</u>		9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u>55</u> Days <u>55</u> Hours <u>55</u> Min. <u>55</u>	IF UNDER 24 HRS. Hours <u>55</u> Min. <u>55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAIL CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>GA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMUEL ANTHONY</u>				14. MOTHER'S MAIDEN NAME <u>RUTH SORREL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>GUSSIE L. ANTHONY - 908-60th Ave. Fairmont Hts, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden death, cause undetermined.</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>2 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>a. 11</u> Month <u>19</u> Day <u>19</u> Year <u>1967</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/16/1966</u> to <u>1/26/1967</u> , that I last saw the deceased alive on <u>1/26/1967</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>919 18th Street, N.W.</u> DATE SIGNED <u>Robert R. Belton</u>							
ACTUAL SIGNATURE <u>Robert R. Belton</u>				M.D. <u>919 18th Street, N.W.</u>			
PHYSICIAN'S NAME (Type) <u>Robert R. Belton</u>				Washington, D. C. 20006			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-2-67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HARMONY MEMORIAL</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOFFMAN FUNERAL HOME 909-6 St. N.W.</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 7 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





01112

CERTIFICATE OF DEATH

01112

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Princess Anne</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Princess Anne</u> b. COUNTY <u>Princess Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN TB <u>3 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cranston</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Princess Anne Hospital</u>		d. STREET ADDRESS <u>201 Laurel Street</u>	
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Robert</u> Last <u>Domestic</u>		4 DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-23-02</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FLORAL</u>	9. AGE (in years) lost (birthdays) <u>64</u> yrs
11. BIRTHPLACE (County & State or foreign country) <u>Portugal</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Roberto</u>		14. MOTHER'S MAIDEN NAME <u>MARIA DOMINGOS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT <u>Hospital records</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>450.0</u> IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>GEN. ARTERIOSCLEROSIS</u> DUE TO (c) <u>UNKNOWN</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ACUTE BRONCHITIS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-22</u> , 19 <u>67</u> , to <u>1-25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-28</u> , 19 <u>67</u> , and that death occurred at <u>6:15 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>C. J. Houmann</u>		22b. DATE SIGNED <u>1-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. J. HOUMANN M.D.</u>		22d. ADDRESS <u>RIVERDALE MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1/26/67</u>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <u>ST ANN'S</u>	23d. LOCATION (City or Town) (County) (State) <u>CRANSTON, RI</u>
24. FUNERAL DIRECTOR <u>W. W. Chambers</u>		25a. REC'D BY REGISTRAR <u>1400 CHAPIN</u>	
25b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>		DATE <u>JAN 30 1967</u>	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

011113

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

011113

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN TB <u>DOA</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>				d. STREET ADDRESS <u>3707 Upshur Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Reginald R Austin</u>				4. DATE OF DEATH Month Day Year <u>1 28 19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 Aug. 1910</u>		9. AGE (In years last birthday) <u>56</u> yrs	10. IF UNDER 1 YEAR Months Days	11. F UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police Lt.--Prince George County Police</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, DC</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>William C. Austin, Sr</u>				14. MOTHER'S MAIDEN NAME <u>Sophia M. Rupple</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <u>Son</u> Address <u>College Park</u>		18. <u>Dorsey W. Austin 9602-51st Pl., Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>Hypertensive arteriosclerotic heart disease</u> (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>over 2 yrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.				22. DATE SIGNED <u>1-30-67</u>			
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 31-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Simmons Bros</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
24. <u>Simmons Bros.-1661-Good Hope Rd SE Wash. DC</u>				DATE <u>JAN 31 1967</u>			



FOR STATE  
HEALTH DEPT.

01114

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01114

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b DCA		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 5741 Porters Lane		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Donald Robert Ball		4. DATE OF DEATH Month 1 Day 5 Year 1967		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12-27-20		9. AGE (in years last birthday) 46 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Produce		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Orvil M Ball		14. MOTHER'S MAIDEN NAME Dorothy Hamilton		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. W 11	
17. INFORMANT Mary J. Ball		Address Riverdale, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure DUE TO (b) Cirrhosis of liver DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH over 2 yrs.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTR BUT NOT CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)		20c. TIME OF INJURY Month, Day, Year Hour 0 m p m 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f. (City or town)		20g. (County)		20h. (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 1-7-67	
ACTUAL SIGNATURE John Keloe		EXAMINER'S NAME (Type) John Keloe M.D., Riverdale, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 9, 1966		23c. NAME OF CEMETERY OR REMOVAL Arlington National	
23d. LOCATION (City or Town) Arlington		23e. (County) Virginia		23f. (State)		24. FUNERAL DIRECTOR F. Gasch's Sons		Address Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE JAN 10 1967		25b. REGISTRAR'S SIGNATURE Judge		25c. REGISTRAR'S NAME Judge		25d. REGISTRAR'S ADDRESS Judge		25e. REGISTRAR'S CITY OR TOWN Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, pending in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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011115

CERTIFICATE OF DEATH

011115

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magnolia Gardens Nursing Home</u>		d. STREET ADDRESS <u>Lanham Severn Road</u>	
3 NAME OF DECEASED (Type or print) <u>John Berberick</u>		4 DATE OF DEATH Month <u>Jan.</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 17, 1898</u>
9. AGE (In years last birthday) <u>89</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-3191</u>	
17. INFORMANT <u>Mrs. H.C. Hayes</u>		2401 - <u>N. Powhatan St.</u> <u>Arlington, Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident &amp; left hemiplegia</u> DUE TO (b) <u>Cerebral vascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>year</u> <u>year</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Major CVA 10 yrs ago. Arteriosclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , to <u>1/21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/21</u> , 19 <u>67</u> , and that death occurred at <u>9:40</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/24/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Church of Ascension</u>	23d. LOCATION (City or Town) (County) (State) <u>Bowie, Md.</u>
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 25 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>



011116

## CERTIFICATE OF DEATH

011116

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CAMP SPRINGS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>So. Maryland General Hospt</u>		d. STREET ADDRESS <u>5104- Bunkley Rd SE</u>	
3 NAME OF DECEASED (Type or print) <u>Laura S. Biggs</u>		4 DATE OF DEATH <u>January 23 1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1-1900</u>
9 AGE (In years lost birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>SAMUEL S. SWANN</u>		14. MOTHER'S MAIDEN NAME <u>Nettie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>William W. Biggs - Same As Item #2</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Vascular Collapse</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> DUE TO <u>Myocardial Infarction</u> (c) <u>Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11:30</u> , 19 <u>67</u> , to <u>1-23</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>19</u> , and that death occurred at <u>8:10 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin M.D.</u>		22b. DATE SIGNED <u>Jan. 23rd 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Alfred R. Lapin</u>		22d. ADDRESS <u>Southern Md. Gen. Hosp., Clinton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 27th-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>Simmons Bros</u>		25a. REC'D BY REGISTRAR	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		DATE <u>JAN 25 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(Signed & Sealed by Funeral Director)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01117						02513					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <b>Prince Georges</b>			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL-Upper Marlboro</b>			a. STATE <b>Maryland</b>			b. COUNTY <b>Prince Geo's</b>		
c. LENGTH OF STAY IN TB <b>Life</b>			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Box 2811, Route 202</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL-Upper Marlboro</b>			d. STREET ADDRESS <b>Route 202, Box 2811</b>		
3. NAME OF DECEASED (Type or print) <b>Charles Sylvester Binger</b>						4. DATE OF DEATH <b>January 30, 1967</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 23, 1878</b>		9. AGE (In years, months, days) <b>88</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tobacco Farming</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>William Binger</b>						14. MOTHER'S MAIDEN NAME <b>Sarah Jane Buchanan</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes give war or dates of service] <b>Unknown</b>						17. INFORMANT <b>Mrs. Hazel L. Moore-#2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Myocardial Infarction</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 1967</b> to <b>Jan 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan 1967</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>A. Clark Holmes, M.D.</b>						22b. DATE SIGNED <b>1/30/67</b>					
22c. PHYSICIAN'S NAME (Type) <b>A. Clark Holmes, M.D.</b>						22d. ADDRESS <b>Upper Marlboro, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/2/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Cemetery</b>		23d. LOCATION (City, town or county)		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Upper Marlboro, Md.</b>						25. REC'D BY REGISTRAR <b>FEB 14 1967</b>					
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											

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01118

CERTIFICATE OF DEATH

01117

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 7 mos., 3 wks.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
f. STREET ADDRESS 802 9th St., N. E.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joshua Middle - Last Bingham		4. DATE OF DEATH Month 1 Day 11 Year 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/1914
9. AGE (In years last birthday) 52 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman		10b. KIND OF BUSINESS OR INDUSTRY Odd Jobs	
11. BIRTHPLACE (County & State, or foreign country) Bennettsville, S. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Bingham		14. MOTHER'S MAIDEN NAME Hattie Ache	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 579-03-2201	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 002.1 DUE TO (b) Status post left upper lobectomy for pulmonary tuberculosis DUE TO (c) Pulmonary tuberculosis			INTERVAL BETWEEN DEATH 3 hours 2 days 13 months
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis; diabetes mellitus			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 5/23/1966, to 1/11/1967, that (X) (we) last saw the deceased alive on 1/11/1967, and that death occurred at 6:45 PM, from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 1/11/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 1-17-1967	23c. NAME OF CEMETERY OR CREMATORY Hickory	23d. LOCATION (City or Town) (County) (State) Takoma Park Maryland
24. FUNERAL DIRECTOR W. E. Jannin Co		25a. REC'D BY REGISTRAR DATE 1-15-67	
25b. REGISTRAR'S SIGNATURE M. E. Jannin		25c. ADDRESS 1432 You St N.W.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in the space provided on page 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01119

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01118

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>		c. LENGTH OF STAY IN 1b <b>1 hour</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Andrews Air Force Base Hospital</b>		e. STREET ADDRESS <b>236 Herring Avenue</b>	
3 NAME OF DECEASED (Type or print) <b>Lee Kelly aka Thomas Beverly Blake</b>		4 DATE OF DEATH Month <b>1</b> Day <b>19</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>8-1-1894</b>
9 AGE (In years last birthday) <b>72 yrs</b>		10 IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>67</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>	
11 BIRTHPLACE (State or foreign country) <b>Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>James E. Kelly</b>		14 MOTHER'S MAIDEN NAME <b>Florence</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>Unk.</b>		16 SOCIAL SECURITY NO <b>Unk.</b>	
17 INFORMANT <b>Mrs. Mary Lee Hutchins-Fairhaven, Md.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH days <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>1-20-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL	23b. DATE THEREOF <b>1/23/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Calvary Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Richmond, Virginia</b>
24. FUNERAL HOME <b>Funeral Home</b>		25a. REC'D BY REG. STRAR DATE <b>JAN 24 1967</b>	
ADDRESS <b>Richmond, Virginia</b>		25b. REG. STRAR'S SIGNATURE <b>Charles Judge</b>	



01120

## CERTIFICATE OF DEATH

01119

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b 70 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		d. STREET ADDRESS 3390 CURTIS DRIVE	
3. NAME OF DECEASED (Type or print) First Middle Last MARIA I. BOGGS		4. DATE OF DEATH Month Day Year JANUARY 9 1967	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 MAY 1928
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) TRIESTE, ITALY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME FRANCESCO COLOCO		14. MOTHER'S MAIDEN NAME ANTONIA PACUCCI	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO N/A		16. SOCIAL SECURITY NO. 578-48-7553	
17. INFORMANT WILLIS BOGGS-SAME AS #2 ABOVE		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>PULMONARY METASTASES</u> DUE TO (c) <u>BREAST CANCER</u>		INTERVAL BETWEEN ONSET AND DEATH 5 MIN 6 MONTHS 9 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>31 OCT</u> , 19 <u>66</u> , to <u>9 JAN</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>9 JAN</u> , 19 <u>67</u> , and that death occurred at <u>5:30M</u> , from causes and on the date stated above			
22a. SIGNATURE <i>John Bristow</i>		22b. DATE SIGNED 9 JAN 67	
22c. PHYSICIAN'S NAME (Type) JOHN BRISTOW, CAPT, USAF, MC		22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/12/67	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR C.M. Graves		25a. REC'D BY REGISTRAR JAN 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/68

01121

CERTIFICATE OF DEATH

01120

1 PLACE OF DEATH a COUNTY <u>Princess George's</u> <u>HOME</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD.</u> b COUNTY <u>Prince Geo.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adolph</u>		c LENGTH OF STAY IN 1b <u>From Dec-5</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Paint Branch Nursing Home</u>		d STREET ADDRESS <u>1310 Brooklyn Blvd</u> <u>2226 Powder Mill Rd</u>	
3 NAME OF DECEASED (Type or print) <u>Albert</u> <u>Bounds</u>		4 DATE OF DEATH Month <u>1</u> Day <u>30</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-6-1876</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11 BIRTHPLACE (County & State, or foreign country) <u>Howard Co.</u>
13 FATHER'S NAME <u>Edward Claggett</u>		14 MOTHER'S MAIDEN NAME <u>Johanna Watkins</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>219-54-9194</u>	17 INFORMANT <u>Mary Walker</u> Address <u>13015 Tamarack</u>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive-arteriosclerotic Heart Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs</u> <u>1 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Terminal B.F. Hemorrhage</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-16</u> , 19 <u>65</u> , to <u>1-30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-25</u> , 19 <u>67</u> , and that death occurred at <u>4:45 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>R.D. Bauer MD</u>		22b DATE SIGNED <u>1-30-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.D. Bauer, MD.</u>		22d ADDRESS <u>2513 Bullock Rd. Pk. Pk., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-2-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arrian Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>
24 FUNERAL DIRECTOR <u>De Witt Donaldson</u>		25a REC'D BY REGISTRAR DATE <u>FEB 6 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>John J. Judge</u>	





CERTIFICATE OF DEATH

Reg. Dist. No. 01121

01122

1. PLACE OF DEATH a. COUNTY Prince Geo.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		111	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Geo. Gen. Hosp.				d. STREET ADDRESS 2705 - Upshur St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lula L. Breland				4. DATE OF DEATH Month Day Year Jan. 1 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/9/1872		9. AGE (In years last birthday) 94 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Miss.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Wiley Lowrey				14. MOTHER'S MAIDEN NAME Mary Hunt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-56-1869		17. INFORMANT Ora L. Breland (above address)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Congestive Heart failure (Dtr.) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 week Years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 31, 1966, to Jan. 1, 1967, that I last saw the deceased alive on Dec. 31, 1966, and that death occurred at 7411 Riggs Rd, Hyattsville, Md, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Ronald S. Fleischer, M.D. 1-2-67 PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/5/67		22c. NAME OF CEMETERY OR CREMATORY Loakesville Com.		22d. LOCATION (City, town, or county) (State) Loakesville, Miss.	
23. FUNERAL DIRECTOR'S SIGNATURE Funeral Home Inc.				ADDRESS Maryland		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Released by Coroner



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01123

## CERTIFICATE OF DEATH

01122

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>5305 Old Temple Hill Rd.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary G Brightwell</b>		4. DATE OF DEATH Month Day Year <b>Jan 23 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>24 Feb. 1890</b>
9. AGE (In years last birthday) <b>76 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>19 23 19 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>? Padgett</b>		14. MOTHER'S MAIDEN NAME <b>Mary Pickeral</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Ruth V. Downs-5358 Old Temple Hills Rd SE</b>		Address <b>Temple Hills Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO (b) <b>DIABETES MELLITUS</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>LOBAR PNEUMONIA - CEREBRAL ARTERIO SCLEROSIS</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12/1/66</b> to <b>1/23, 1967</b> , that (I) (we) last saw the deceased alive on <b>1/23, 1967</b> , and that death occurred at <b>8:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Bruno Kolesch</b>		22b. DATE SIGNED <b>1/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Bruno Kolesch</b>		22d. ADDRESS <b>4400 STAMIS RD. TEMPLE HILLS - MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 27-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Barnabas Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Oxon Hill, Maryland</b>
24. FUNERAL DIRECTOR'S ADDRESS <b>Simmons Bros.-1661-Good Hope Rd SE Wash DC</b>		25a. REC'D BY REGISTRAR <b>JAN 25 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film G384 1/17/67 mh

01124

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01123

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cleverly		c. LENGTH OF STAY IN 1b PCA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coral Hills			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 1401 Boone Hill Road		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Franklin Roosevelt Brown				4. DATE OF DEATH Month Day Year 1 5 19 67			
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-26-35	9. AGE (In years last birthday) 31 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Marion Brown 1401- Boone Hill Rd. S.E.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO 512 Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Congestive heart failure</u> DUE TO (c) <u>Congenital heart disease (inter ventricular septal defect)</u>							INTERVAL BETWEEN ONSET AND DEATH hours over 6 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. NATURE OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							22. DATE SIGNED 1-7-67
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Prince M.D. John Prince M.D., Silverdale, Md		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 1-7-67	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town)		(County)	(State)
24. FUNERAL DIRECTOR R.N. Hortonco 1324 4th St NW		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



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FOR STATE  
HEALTH DEPT.

01125

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01124

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Oaks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 5411 Chapel Oaks Drive	
3. NAME OF DECEASED (Type or print) First Middle Last Hattie Middleton B ryant		4. DATE OF DEATH Month Day Year 1 20 19 67	
5. SEX F	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Feb., 1894
9. AGE (In years last birthday) 72 yrs.		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS <input type="checkbox"/> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH-PLACE (State or foreign country) Marion Co., S. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Middleton		14. MOTHER'S MAIDEN NAME Alice Hayes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-20-1180	
17. INFORMANT Mrs. Alice LaGrand, 5411 Chapel Oak, Dr. -Mrs. Chapel Oaks, P.G., Co., Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 420.0 IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH Days over 6 months			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale, Md.		22. DATE SIGNED 1-21-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-25-1967	
23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cem.		23d. LOCATION (City or town) (County) (State) Suitland, P. G., Md.	
24. FUNERAL DIRECTOR Hall Bros. Funeral Home 621 E. Ave., N.W., Washington, D.C.		25a. REC'D BY REGISTRAR DATE JAN 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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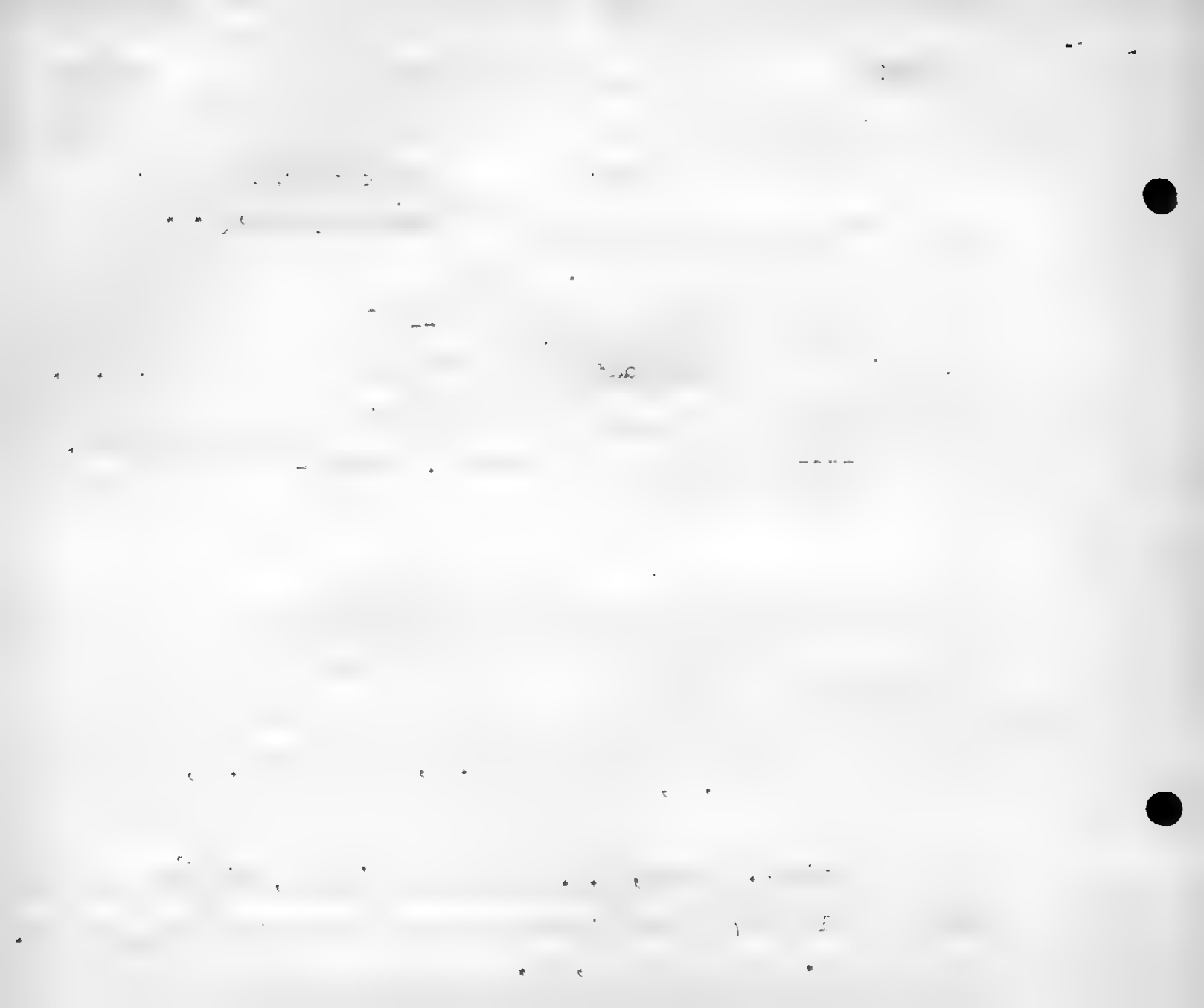
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01126

CERTIFICATE OF DEATH

01125

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>34</b> <del>xxxx</del> Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton Heights Ritchie</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>6300 Ritchie Spur. S.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Blanche</b> Middle <b>L.</b> Last <b>Buckler</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>9</b> Year <b>19 67</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 21 May., 1907</b>	
9. AGE (In years last birthday) <b>59 yrs</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		11. IF UNDER 24 HRS Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tenant</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Sam Goldsmith</b>				14. MOTHER'S MAIDEN NAME <b>Cora Chin</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>----</b>		17. INFORMANT <b>James P. Buckner-</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> DUE TO (b) <b>myocardial infarction</b> DUE TO (c) <b></b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>Dec. 6, 1966</b> , to <b>Jan. 9, 1967</b> , that (1) (we) last saw the deceased alive on <b>Jan. 9, 1967</b> , and that death occurred at <b>12:45 AM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Edwin J. Jensen</b>				M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Jan. 9, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>				22d. ADDRESS <b>Pr. Geo Hospital Cheverly, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/12/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Old Fields Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hughsville Charles Md.</b>	
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 13 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

01127

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01126

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY in 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>Rt. 2, Box 340</b>	
3 NAME OF DECEASED (Type or print) <b>Kenneth Wayne Burkett</b>		4. DATE OF DEATH Month <b>1</b> Day <b>22</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>11-3-1928</b>
9 AGE (In years lost birthday) <b>38</b> yrs		10 IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		11 BIRTHPLACE (State or foreign country) <b>Black Sea, Russia</b>	
12 CT ZEN OF WHAT COUNTRY?		13 FATHER'S NAME <b>Leuther B. Burkett</b>	
14 MOTHER'S MAIDEN NAME <b>Sarah Burkett</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO.		17 INFORMANT <b>John Kehoe</b> Address <b>1734 17th St, Baltimore, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>919.8</b> IMMEDIATE CAUSE (a) <b>Gun shot wound of brain</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Shot by accident ..... revolver</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>6:00am 1-22-1967</b>	20d. INJURY OCCURRED Where <input type="checkbox"/> at work <input type="checkbox"/> at home <input checked="" type="checkbox"/> elsewhere <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>300A Schall Road, Accokeek, Md.</b>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from <b>Natural causes</b> <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		22 DATE SIGNED <b>1-23-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>1-24-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery, Riverdale, Md.</b>	23d. LOCATION (City or Town) (County) (State) <b>Riverdale, Md.</b>
24. FUNERAL DIRECTOR <b>John Kehoe, M.D.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JAN 27 1967</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 18-3177

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01128

## CERTIFICATE OF DEATH

01127

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

released by Dr. P. Kehoe - 1/7/67 5:30 pm.

1. PLACE OF DEATH a. COUNTY <u>Pr Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Pr Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Md.</u>		c. LENGTH OF STAY IN 1b <u>15 1/2 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6724 Fairwood Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Elaine Burnston</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 6 1896</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harry Shipley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Holtman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>220-32-5600</u>	
17. INFORMANT <u>Geo. Burnston</u>		Address <u>6724 Fairwood Rd. Hyattsville Ind</u>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pul. Embolism</u> DUE TO <u>Chronic Myocardial Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Emphysema</u> (b) <u>Chronic Myocardial Hypertension</u> (c) <u>Emphysema</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>2 1/2 hrs.</u> <u>3 yrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/6/52</u> , 19 <u>52</u> to <u>1/7/67</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>12/11/66</u> , and that death occurred at <u>1/7/67</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>H.T. Morse</u>		22b. DATE SIGNED <u>1/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H.T. Morse M.D.</u>		22d. ADDRESS <u>7030 Carroll Ave Takoma Park Ind</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 10 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>254 Carroll Ave NW DC</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 11 1967</u>	



01129

CERTIFICATE OF DEATH

01128

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1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Mayrland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine	
c. LENGTH OF STAY IN 1b 49 days		d. STREET ADDRESS Rt. 382 = Box 194	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Leroy Middle H Last Butler		4. DATE OF DEATH Month Jan. Day 4 Year 19 67	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5 June, 1923
9. AGE (In years last birthday) 43 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mech.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Butler		14. MOTHER'S MAIDEN NAME Margariete. Berry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Frances Butler		Address Rt. 382 - Box 194 Brandywine, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic failure 5810 DUE TO (b) Cirrhosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) Hematoma		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov. 16, 1966, 19 to Jan. 4, 1967, that (I) (we) last saw the deceased alive on Jan. 3, 1967, and that death occurred at 3:30 AM, from causes and on the date stated above.			
22a. SIGNATURE Edwin J. Jensen		22b. DATE SIGNED Jan. 4, 1967	
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.		22d. ADDRESS Prince George's General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 7, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Thomas Church Cem.	23d. LOCATION (City or town) Brandywine, Md. (County) Prince Georges (State) Maryland
24. FUNERAL DIRECTOR		25a. REC'D BY REG. STRAR 25b. REGISTRAR'S SIGNATURE	
MARSHALL ADAMS		DATE JAN 11 1967 Charles Judge	





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## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3117 Parkway Terrace Drive</b>		d. STREET ADDRESS <b>3117 Parkway Terrace Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Monnie</b> Middle <b>L.</b> Last <b>Calico</b>		4. DATE OF DEATH Month <b>Jun.</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21, 1903</b>
9. AGE (In years last birthday) <b>63 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Clerk</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Cecil Lyon</b>		14. MOTHER'S MAIDEN NAME <b>Elsie Ingram</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Geneva Spence</b>		Address <b>3121 Parkway Terr Drive</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Ac. Myocardial Infarction.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus - Pernicious Anemia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1944</b> , 19 to <b>1-14</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>1-14</b> 19 <b>67</b> , and that death occurred at <b>9 P.</b> M. from causes and on the date stated above.			
22a. SIGNATURE <b>Bernard Katzman</b>		22b. DATE SIGNED <b>1-25-67.</b>	
22c. PHYSICIAN'S NAME (Type) <b>BERNARD KATZMAN</b>		22d. ADDRESS <b>2645-Waylen Rd-S.E.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-27-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Maryland</b>	
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b>		25a. REC'D BY REGISTRAR <b>JAN 27 1967</b>	
ADDRESS <b>4308 Suitland Rd Suitland Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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01131

## CERTIFICATE OF DEATH

01130

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>15 days</b>	c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Hyttsville</b>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d STREET ADDRESS <b>-6500 Riggs Road</b>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Leonice (NMI) Capretti</b>		4. DATE OF DEATH Month Day Year <b>Jan., 1 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 July 1890</b>
9 AGE (In years last birthday) <b>76</b> yrs		10 IF UNDER 1 YEAR Months Days <b>1 19 67</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State or foreign country) <b>Italy</b>
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13 FATHER'S NAME <b>Giovanno DiGirolmo</b>	
14. MOTHER'S MAIDEN NAME <b>unknown</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>215-54-7404</b>		17. INFORMANT <b>Sunday Capretti (son)</b> Address <b>6203 - 20th Place, W. Hyattsville, Md.</b>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Coronary Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Thrombosis of right renal and splenic arteries</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 1966</b> to <b>1 Jan. 1967</b> , that (I) (we) last saw the deceased alive on <b>1 Jan. 1967</b> and that death occurred at <b>3:50 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Wm A. Wimsatt</b>		22b. DATE SIGNED <b>2 Jan. 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>William A. Wimsatt, MD</b>		22d. ADDRESS <b>3415 Hamilton St., Hyattsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4 Jan. 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, DC</b>
24. FUNERAL DIRECTOR <b>RINALDI FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>WASH-D.C.</b>	
25b. REGISTRAR'S SIGNATURE <b>W. J. Judge</b>		DATE <b>JAN 4 1967</b>	

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01132

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01131

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE CO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4922 LASHILLE RD. CARROLL HUNTER		d. STREET ADDRESS 5915 Sonoma Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last ANNA M. CARLSON		4. DATE OF DEATH Month Day Year JAN 4 1967	
5. SEX FEM.	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16 - 1897
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Mln.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) WASH. D.C.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME MARTIN MULROE	
14. MOTHER'S MAIDEN NAME MARY LULL		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. 577-03975		17. INFORMANT SR. CHRISTINE 4922 LASHILLE RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Edynamic Aneurysm</i> DUE TO (b) <i>Sarkous Disease</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 4 hrs 40 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 3, 1958, to Jan 4, 1967, that (I) (we) last saw the deceased alive on Dec 24, 1966, and that death occurred at 10:00 AM, from the causes and on the date stated above.			
22a. SIGNATURE Francis P. Hannan M.D.		22b. DATE SIGNED Jan 4, 1967	
22c. PHYSICIAN'S NAME (Type) FRANCIS P. HANNAN		22d. ADDRESS 1511-17 ST. NW WASH. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-7-67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town or county) (State) Washington, D. C.
24. FUNERAL DIRECTOR Robert G. Humphrey		25a. REC'D BY REGISTRAR JAN 9 1967	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION



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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

01133

01132

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN ID <b>20 HR 2 MIN</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>COLLEGE PARK</b> d. STREET ADDRESS <b>8502 CUNNINGHAM DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MICHELE LYN CARPENTER</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>23</b> Year <b>1967</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>22 JAN 1967</b>	
9. AGE (In years last birthday) <b>20</b>		10. AGE (In years last birthday) <b>2</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PRINCE GEORGE'S, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>			
13. FATHER'S NAME <b>JAMES CLARANCE CARPENTER</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE EMILY OLIVER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>SAME AS #2 ABOVE</b> <b>CATHERINE E. CARPENTER-MOTHER</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ERYTHROBLASTOSIS FETALIS</b> 7:00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>20 HOURS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>22 JAN 1967</b> , to <b>23 JAN 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>23 JAN 1967</b> , and that death occurred at <b>7:00 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Phillip Steiner</i>				22b. DATE SIGNED <b>23 JAN 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>PHILLIP STEINER, CAPT, USAF, MC</b>				22d. ADDRESS <b>USAF HOSPITAL ANDREWS</b> <b>ANDREWS AFB, WASHINGTON D.C. 20331</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>20 JAN 67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PUBLIC CREMATION</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <i>Carl A. Curren</i>				25a. REC'D BY REGISTRAR <b>DATE JAN 30 1967</b>			
				25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and inform the event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

Item 18 Film 386 2-27											
MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
01133 01133											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights 1611			d. STREET ADDRESS 1009 Brooks Road			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Shirley SHORE K. Carroll			First Middle Last		4. DATE OF DEATH 1 23 19 67		Month Day Year				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 April 1923 43 yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) School Teacher			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Minnesota			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Victor R. Lanes					14. MOTHER'S MAIDEN NAME						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Paul G. Carroll			Address 1009 Brooks Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH Unk.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE John Kehoe, M.D.			EXAMINER'S NAME (Type) John Kehoe, M.D.			22. DATE SIGNED 1-24-67			Address (Street, city, town, or county) Riverdale, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1-27-1967		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia				
24. FUNERAL DIRECTOR Wilhelm Funeral Home			ADDRESS 4308 Suitland Rd		25a. REC'D BY REGISTRAR JAN 27 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge				
DATE			Maryland								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1M

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

01135

01134

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> c. LENGTH OF STAY IN b. <u>3 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3202 Beltsville Road</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) STATE <u>Maryland</u> COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> d. STREET ADDRESS <u>3202 Beltsville Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Charles</u> Middle <u>Edward</u> Last <u>Carter</u>		<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>17</u> Year <u>1967</u>	
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Sept. 13, 1895</u>
<b>9. AGE</b> (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Blacksmith</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Government</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>North Lawrence, Ohio</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>William Carter</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Maria Knapper</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>578-38-9430</u> <b>17. INFORMANT</b> <u>Ruth L. Carter</u> Address <u>3202 Beltsville Road, Beltsville, Maryland</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Colon &amp; Metastasis</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>about 1 yr</u>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>67</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Oct 1966</u> <b>to</b> <u>17 Jan. 1967</u> <b>that (I) (we) last saw the deceased alive on</b> <u>13 Jan. 1967</u> <b>and that death occurred at</b> <u>12:10 AM</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>William D. And</u> M.D.		<b>22b. DATE SIGNED</b> <u>11/17/67</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>William D. And</u>		<b>22d. ADDRESS</b> <u>9006 Colesville Road, Silver Spring, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>Jan 20, 1967</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Washington National Cemetery</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>Suitland, Maryland</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John B. Thomas</u> ADDRESS <u>8434 Georgia Avenue, Silver Spring, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>20 1967</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles</u>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01136

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01135

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL-UPPER MARLBORO				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) JUNCTION OF CROOM STATION ROAD AND CROOMS ROAD, UPPER MARLBORO				d. STREET ADDRESS 4402 ATWICK ROAD			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle (NMN) Last CASPARI III				4. DATE OF DEATH Month JANUARY Day 8 Year 19 67			
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 JUN 1935	
9. AGE (in years last birthday) 31 yrs.		10. FUNDER 1 YEAR Months Days		11. FUNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER				10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME WILLIAM (NMN) CASPARI JR				14. MOTHER'S MAIDEN NAME LENA (NMN) CHAO			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1958-1962				16. SOCIAL SECURITY NO. 216-34-2894		17. INFORMANT OFFICIAL U.S. NAVY RECORDS Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INJURIES MULTIPLE EXTREME DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AIRCRAFT ACCIDENT			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 1107 308 8 JAN 19 67				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) FARM	
20f. (City or town) NEAR UPPER MARLBORO, MD				20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE JOHN KEHOE, MD				22. DATE SIGNED 9 JAN 1967			
EXAMINER'S NAME (Type)				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF 1-11-1967		23c. NAME OF CEMETERY OR CREMATORY LODGE PARK CEMETERY BALTO MD	
23d. LOCATION (City, town or county) (State)				24. FUNERAL DIRECTOR W.D. Chambers C222 1400 E. 1st St. Wash D.C.			
25a. REC'D BY REGISTRAR DATE JAN 13 1967				25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01137

CERTIFICATE OF DEATH

01136

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Leland Memorial Hospital</b>				e. STREET ADDRESS <b>4517 Madison Street</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Della</b> Middle <b>Anastacia</b> Last <b>CHANEY</b>				4. DATE OF DEATH Month <b>January</b> Day <b>8</b> Year <b>19 67</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/3/91</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles Yeager</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Dix</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Son Owen B. Chaney</b> Address <b>3940 Madison St. Hyattsville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>175.0</b> DUE TO <b>Ovarian Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b> <b>12/19/66 to 9-12 MONTHS</b> <b>1/8/67</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-19</b> , 19 <b>66</b> , to <b>1-8</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>1-8</b> , 19 <b>67</b> , and that death occurred at <b>9:15 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>C.J. Houmann</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-8-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>C.J. Houmann, M.D.</b>				22d. ADDRESS <b>4404 Queensbury Road, Riverdale, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 10, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>St Johns Episcopal</b>		23d. LOCATION (City or Town) (County) (State) <b>Beltsville Prp Geo Md.</b>	
24. FUNERAL DIRECTOR <b>P. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 10 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	





01138

CERTIFICATE OF DEATH

01137

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>9039 Sligo Creek Parkway</b>	
3 NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>BRYANT</b> Last <b>CHASM</b>		4 DATE OF DEATH Month <b>JANUARY</b> Day <b>3</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 25, 1917</b>
9 AGE (n years last birthday) yrs. <b>49</b>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman (RET)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Appliances</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Chasm</b>		14. MOTHER'S MAIDEN NAME <b>Anna ? ? ? ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>063-01-4220</b>	
17. INFORMANT <b>Mrs. Mollye D. Chasm,</b>		Address <b>Same as 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>2340.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 25, 1964</b> , to <b>12-21, 1966</b> , that (I) (we) last saw the deceased alive on <b>12-21, 1966</b> , and that death occurred at <b>6:00 P.M.</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>Isidore Shulman</b>		22b. DATE SIGNED <b>1-4-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Isidore Shulman</b>		22d. ADDRESS <b>9-5-19th St N.W. D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan 6, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arl. Natl. Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Arl., Va.</b>
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 5 1967</b>	
ADDRESS <b>4217 9th St. N.W.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

Cleared with Medical Examiner Dr. John Kehoe

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or in any event, within 72 hours after death.



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**01139**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**01140**

1. PLACE OF DEATH a COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince George's</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c LENGTH OF STAY IN ID <u>DOA</u>		c (CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's Hospital</u>				d STREET ADDRESS <u>3200 76th Avenue</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Robert Del no Cole</u>			4 DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1967</u>				
5 SEX <u>Male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>March 1, 1942</u>		9 AGE (in years last birthday) <u>24</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Mgr.</u>		10b KIND OF BUSINESS OR INDUSTRY <u>7-11</u>		11 BIRTHPLACE (State or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert E. Cole</u>			14 MOTHER'S MAIDEN NAME <u>Madge Wimmer</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>226-52-4502</u>		17. INFORMANT <u>Mrs. Frances Cole (above address)</u> <u>(Wife)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Gunshot wound of chest</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Shot self with .12 gauge shotgun.</u>					
20c TIME OF INJURY Month, Day Year Hour a.m. <u>  </u> p.m. <u>1-27-67</u> 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f (City or town) (County) (State) <u>Same as #2</u>	
21 I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u>		22. DATE SIGNED <u>1-27-67</u>					
EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u>		23a BURNING, CREMATION, REMOVAL (Specify) <u>Burial</u>					
23b DATE THEREOF <u>2/2/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Cole Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Jewel Valley, Va.</u>			
24 FUNERAL DIRECTOR <u>Nailey's Funeral Home Inc.</u>		ADDRESS <u>Mt. Rainier, Maryland</u>		25a REC'D BY REG STRAR DATE <u>FEB 1 1967</u>		25b REG STRAR'S SIGNATURE <u>Wanda Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01140

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01138

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> <i>Point Branch Nursing Home</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Adelphi</i> c. LENGTH OF STAY IN 1b <i>From Sept 22</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>3120 Powder Mill Rd</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Prince George's</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesverly</i> d. STREET ADDRESS <i>2209 Parkway</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First <i>Willis</i> Middle <i>A.</i> Last <i>Cole</i>		4. DATE OF DEATH Month <i>1</i> Day <i>26</i> Year <i>1967</i>		5. SEX <i>m.</i>		6. COLOR OR RACE <i>w</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-7-88</i>		9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Maine</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>											
13. FATHER'S NAME <i>A.D. Cole</i>				14. MOTHER'S MAIDEN NAME <i>Nellie Folsom</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>578-09-4612</i>				17. INFORMANT <i>Mary Wallace</i> Address <i>13015 Tamarack Rd</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO (b) <i>Arteriosclerosis</i> DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Previous C.V.A. with hemiplegia</i>												INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>10 yrs.</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) <del>this hospital</del> attended the deceased from <i>10-26, 1966</i> to <i>1-26, 1967</i> , that (I) <del>was</del> last saw the deceased alive on <i>1-25, 1967</i> , and that death occurred at <i>8:50 AM</i> , from the causes and on the date stated above.																							
22a. SIGNATURE <i>R.D. Bauer M.D.</i>												22b. DATE SIGNED <i>1-26-67</i>											
22c. PHYSICIAN'S NAME (Type) <i>R.D. Bauer M.D.</i>												22d. ADDRESS <i>2513 Buckledge Rd. Adelphi Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>Jan 28, 1967</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln Cemetery</i>				23d. LOCATION (City, town or county) (State) <i>Colmar Manor Pro Geo Md.</i>											
24. FUNERAL DIRECTOR <i>F. Gasch's Sons Hyattsville, Md.</i>												25a. REC'D BY REGISTRAR <i>JAN 30 1967</i>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

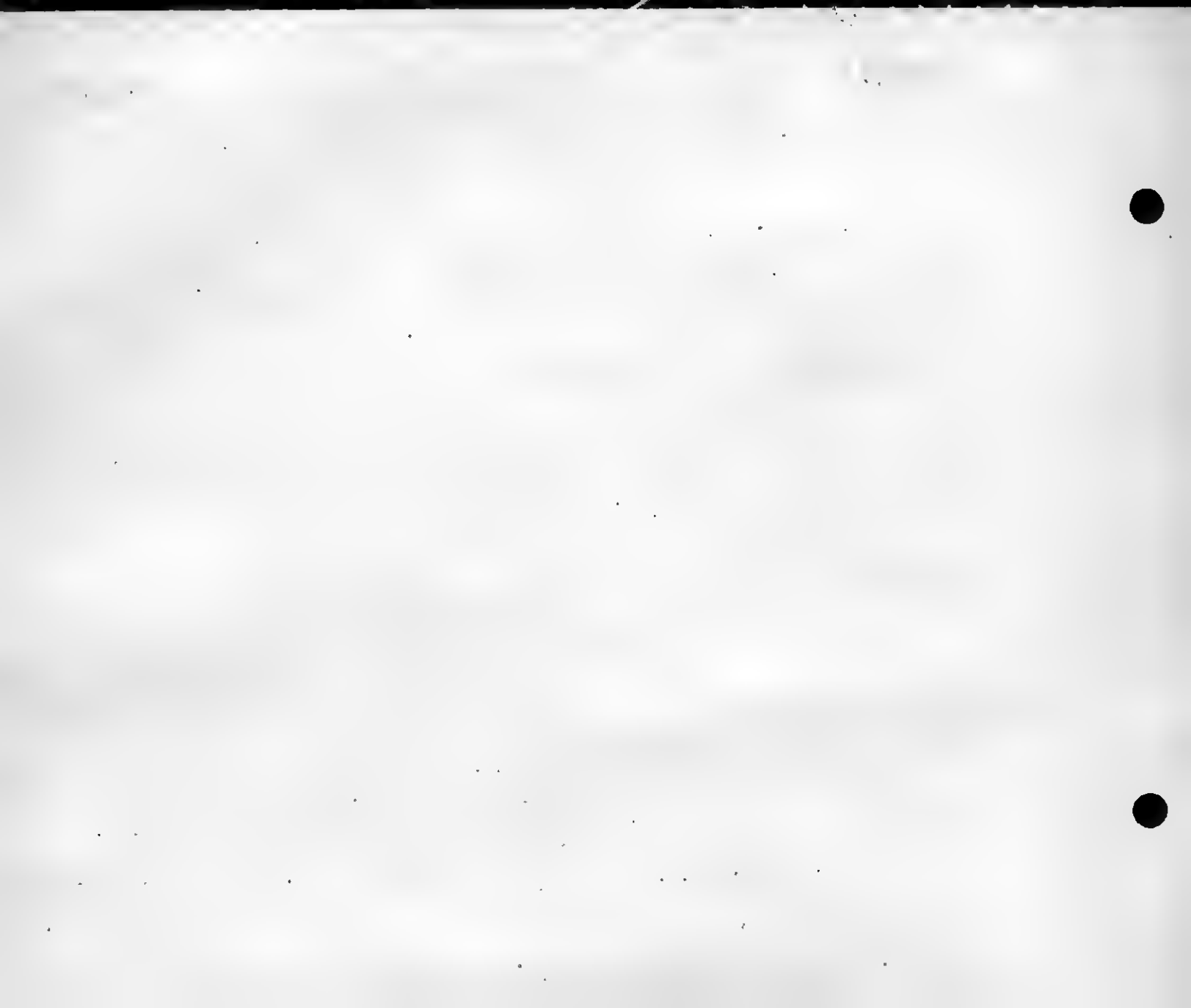
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01141

CERTIFICATE OF DEATH

01139

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 8 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor		d. STREET ADDRESS 3604 41st Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Wilbur A Condit		4. DATE OF DEATH Month Day Year Jan. 23 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 19 Aug., 1900
9. AGE (In years lost birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired decorator		10b. KIND OF BUSINESS OR INDUSTRY Interior decorating	
11. BIRTHPLACE (County & State, or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Sherman Condit		14. MOTHER'S MAIDEN NAME Una Carson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 579 07 0753	
17. INFORMANT Azalee A. Condit		Address Colmar Manor, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 475X DUE TO Cerebral Hemorrhage (b) Hypertensive Cardiovascular Disease (c) DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 15, 1966, to 1/23, 1967, that (I) (we) last saw the deceased alive on 1/20, 1967, and that death occurred at 5:45 PM from causes on and on the date stated above.			
22a. SIGNATURE Peter Duus		22b. DATE SIGNED Jan. 23, 1967	
22c. PHYSICIAN'S NAME (Type) Peter Duus M.D.		22d. ADDRESS 6124 Central Ave. Capitol Hgts. Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 27, 1967	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JAN 30 1967	
25b. REGISTRAR'S SIGNATURE G. J. J. J.			





01142

## CERTIFICATE OF DEATH

01141

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>W. Va</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>11 Days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hedgeville</b>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Otis (Odis)</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>25</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>24 Oct., 1889</b>
9. AGE (In years last birthday) <b>77</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>cotton mill</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maurertown, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Martin Conner</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ellen Smoots</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>215 16 6670A</b>	
17. INFORMANT <b>Orie J. Conner</b>		Address <b>Hedgeville, W. Virginia</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cerebral aneurysm</b> DUE TO (c) <b>Hypertension</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary atherosclerosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>January 14, 1967</b> , to <b>January 25, 1967</b> , that (I) (we) lost saw the deceased alive on <b>January 25, 1967</b> , and that death occurred on <b>6:20A M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>Edwin J. Jensen</b>		22b. DATE SIGNED <b>Jan. 25, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>Jan. 27, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Harrisville, Virginia</b>	23d. LOCATION (City or Town) (County) (State) <b>Harrisville, Va</b>
24. FUNERAL DIRECTOR <b>Witt Danachan</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 6 1967</b>	
ADDRESS <b>Laurel Md</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

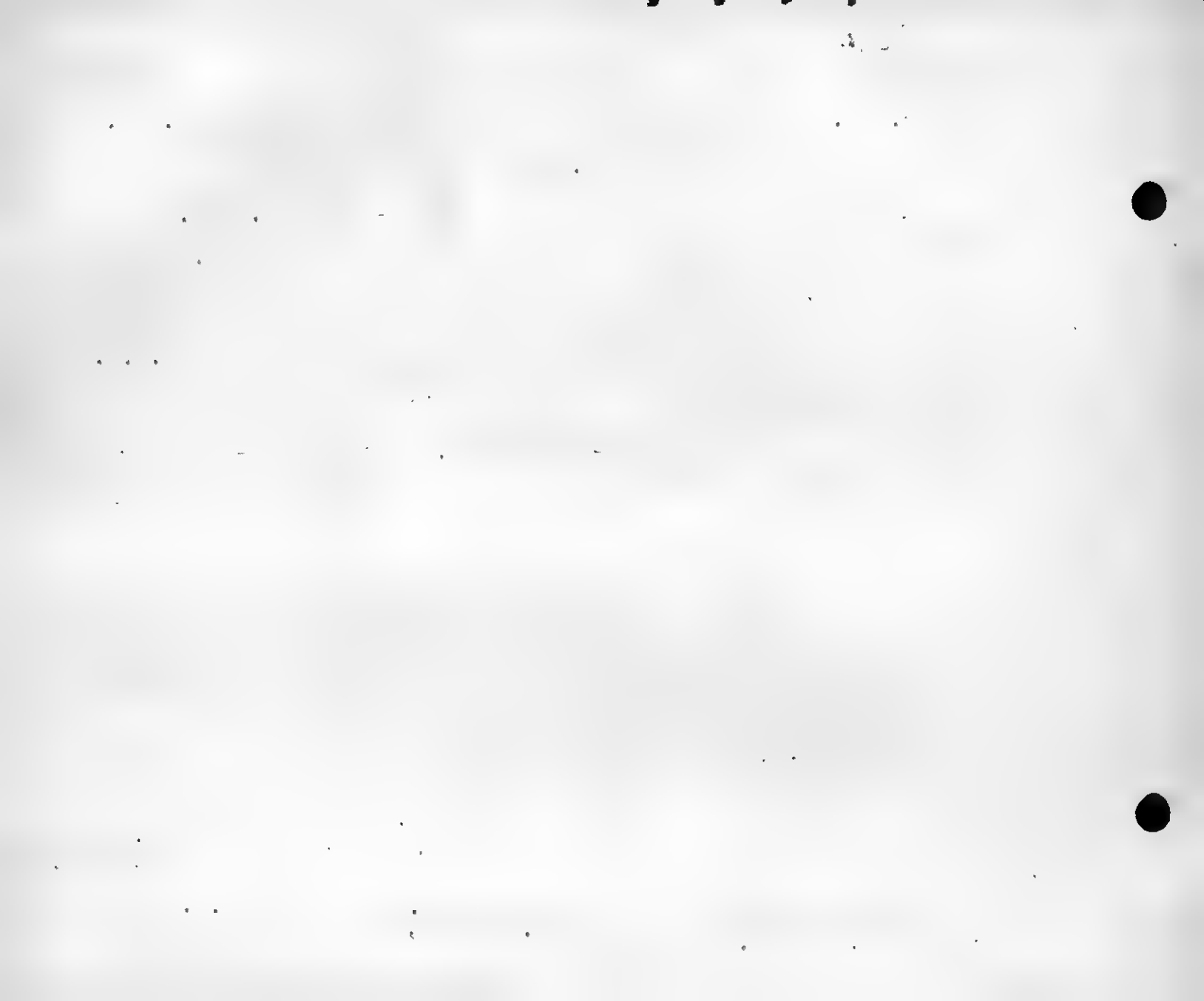
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01143					01142				
1. PLACE OF DEATH a. COUNTY <b>Pr. Geo.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>			c. LENGTH OF STAY IN 1b <b>5 mos. 19 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Paint Branch Nursing Home</b>					d. STREET ADDRESS <b>5309 - 38th St. Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>Connors</b> Last <b>Connors</b>					4. DATE OF DEATH Month <b>Jan.</b> Day <b>22</b> Year <b>1967</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/6/1890</b>		9. AGE (In years last birthday) <b>76</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Ireland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John Gannon</b>					14. MOTHER'S MAIDEN NAME <b>Marie Donnolly</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>113-12-3859A</b>		17. INFORMANT <b>Mrs. Annie Gannon - (above residence)</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident (Sister)</b> <b>3ix</b> DUE TO (b) <b>Atherosclerosis</b> DUE TO (c) <b>Hypertensive cerebrovascular disease</b> CONDITIONS, (if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH <b>6 Days</b> <b>15 yrs.</b> <b>10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-5</b> , 19 <b>66</b> , to <b>1-22</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1-21</b> , 19 <b>67</b> , and that death occurred at <b>9 A.</b> M. from the causes and on the date stated above.									
22a. SIGNATURE <b>R.D. Bauer MD</b>						22b. DATE SIGNED <b>1-22-67</b>			
22c. PHYSICIAN'S NAME (Type) <b>R.D. Bauer MD</b>						22d. ADDRESS <b>2513 Buck Lodge Rd. Conely, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/24/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Raymond's Cem.</b>			23d. LOCATION (City, town or county) (State) <b>Bronx, N.Y.</b>		
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>				25a. REC'D BY REGISTRAR <b>JAN 25 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



01144

CERTIFICATE OF DEATH

01143

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived at institution or residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Hyattsville</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville MD.</u>			
c. LENGTH OF STAY IN <u>5 yrs</u>				d. STREET ADDRESS <u>3920 Livingston Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Leont Branch Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Alfred</u> Last <u>Conover</u>				4. DATE OF DEATH Month <u>1</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-2-1873</u>	
9. AGE (In years) <u>87</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dairy Specialist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hyattsville MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Alfred George Conover</u>		14. MOTHER'S MAIDEN NAME <u>ILLINOIS Mollie Ambrose</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-52-0886</u>		17. INFORMANT <u>Alfred Conover</u> Address <u>Hyattsville MD 3920 Livingston Rd</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>Coronary Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>10 yrs.</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-29</u> , 19 <u>64</u> , to <u>1-14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-11</u> , 19 <u>67</u> , and that death occurred at <u>5 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>R.D. Bauer, MD.</u>				22b. DATE SIGNED <u>1-16-67</u>		22c. PHYSICIAN'S NAME (Type) <u>R.D. Bauer, MD.</u>	
22d. ADDRESS <u>2513 Buck Lodge Rd. Annapolis Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/17/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>Mt. Rainier, Maryland</u>				DATE <u>JAN 19 1967</u>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01145

01144

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		e. STREET ADDRESS 2712 Bellview Avenue	
3 NAME OF DECEASED (Type or print) Ernest		4 DATE OF DEATH Month January Day 28 Year 1967	
5 SEX male	6 COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 20, 1900
9 AGE (in years last birthday) 86 yrs.		10 UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US Gov't. (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY US Park Service	
11 BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME James Cooke		14 MOTHER'S MAIDEN NAME Maryann Washington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-54-6986	
17 INFORMANT Mrs. Elsie E. Cooke		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Peritonitis 550.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Rupture of gangrenous appendix (c)			INTERVAL BETWEEN ONSET AND DEATH days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 1-29-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb 1, 67	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.	23d. LOCATION (City or Town) (County) (State) Colmar Manor. Maryland
24 FUNERAL DIRECTOR Lee Funeral Home. 300 4th St NE. Wash.		25. REG'D BY REGISTRAR DATE FEB 1 1967	
26. REGISTRAR'S SIGNATURE Charles Judge			





FOR STATE  
HEALTH DEPT.

01146

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01145

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN MD TCA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 2723 13rd Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Virginia Frances Couter				4. DATE OF DEATH Month Day Year 1 26 19 67			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-30-99	9. AGE (In years last birthday) 67 yrs	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Walter E Stubblefield				14. MOTHER'S MAIDEN NAME Irene Day Rilee			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 577 07 0152		17. INFORMANT Albert H. Couter Hyattsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Carcinoma of breast</u> DUE TO (c) <u>over 1 yr.</u>						INTERVAL BETWEEN ONSET AND DEATH over 6 mo.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John H. Gasch M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John H. Gasch, M.D., Hyattsville, Md.		22. DATE SIGNED 1-28-67		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan 30, 1967	23c. NAME OF CEMETERY OR CREMATORIUM St Johns Episcopal		23d. LOCATION (City or town) (County) (State) Beltsville Pro Geo Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JAN 30 1967		25b. REGISTRAR'S SIGNATURE John H. Gasch			

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18 14



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ~~An entry should be made in any event, within 72 hours after death.~~ should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)  
20 M 1/66

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01147

01146

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>2 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>4019 - A 3 Warner Avenue</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>Linda</b> Middle <b>Cowley</b> Last <b>Cowley</b>		4 DATE OF DEATH Month <b>Jan</b> Day <b>10</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>7 Oct., 1943</b>
9. AGE (in years last birthday) <b>23 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H/W</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>England</b>	
12. CITIZEN OF WHAT COUNTRY? <b>England</b>		13. FATHER'S NAME <b>George McKie</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Wm. Cowley (above address)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Corio - Epithelioma - Metastasis</b> (c) <b>to Lung &amp; Brain</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1-8</b> , 19 <b>67</b> , to <b>1-10</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>8:15 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>CHARLES JUDGE</b>		22b. DATE SIGNED <b>Jan. 11, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES JUDGE</b>		22d. ADDRESS <b>5813 Landover Ave (Ches), Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/14/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Liverpool, England</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JAN 17 1967</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

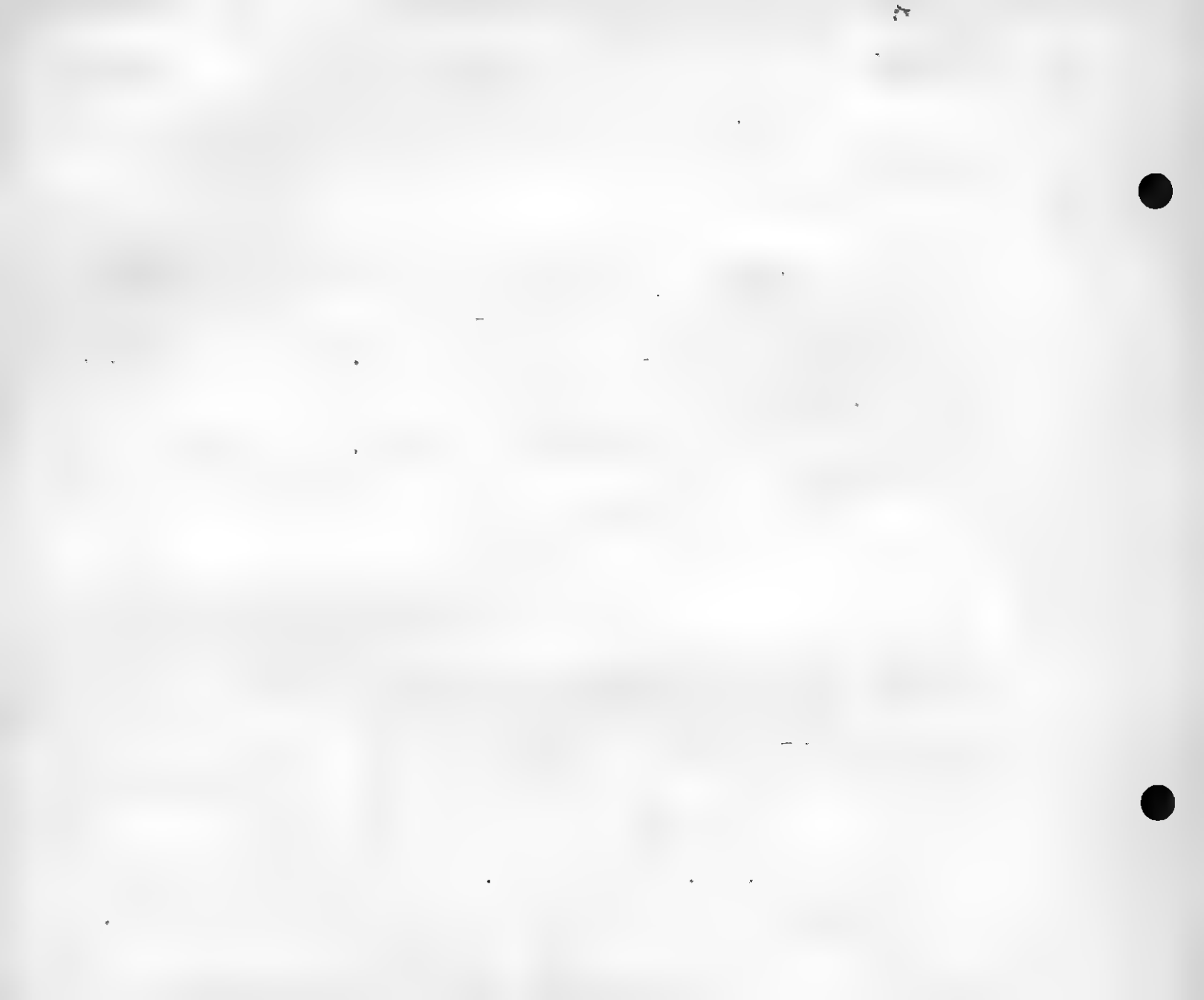
## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01148

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01147

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c LENGTH OF STAY IN 1b <b>DOA</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chamber's Funeral Home</b>				d STREET ADDRESS <b>5115 Upshur Street</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Jane Esther (Howard) Cross</b>				4 DATE OF DEATH Month <b>1</b> Day <b>2</b> Year <b>19 67</b>			
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1-16-1913</b>		9 AGE (In years lost birthday) <b>53</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>-</b>		11 BIRTHPLACE (State or foreign country) <b>Penna.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Clyde W. Howard</b>				14 MOTHER'S MAIDEN NAME <b>Sarah Morris</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>174-12-0910</b>		17 INFORMANT Address <b>Mr. Terry M. Cross (above address) (Husband)</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. <b>916.0 IMMEDIATE CAUSE (a) Asphyxia</b> DUE TO <b>Inhalation of smoke</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) _____ DUE TO (c) _____							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Trapped in house fire</b>					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>7:20am</b> <b>1-2- 1967</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f (City or town) (County) (State) <b>Same as #2</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		22. DATE SIGNED <b>1-2-67</b>					
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		<b>Riverdale, Md.</b>		Address (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>1/5/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Pt. Lincoln Com.</b>		23d LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR <b>Malloy's Funeral Home Inc.</b>				ADDRESS <b>Mt. Rainier Maryland</b>		25a REC'D BY REGISTRAR DATE <b>JAN 9 1967</b>	
				25b REGISTRAR'S SIGNATURE <b>[Signature]</b>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

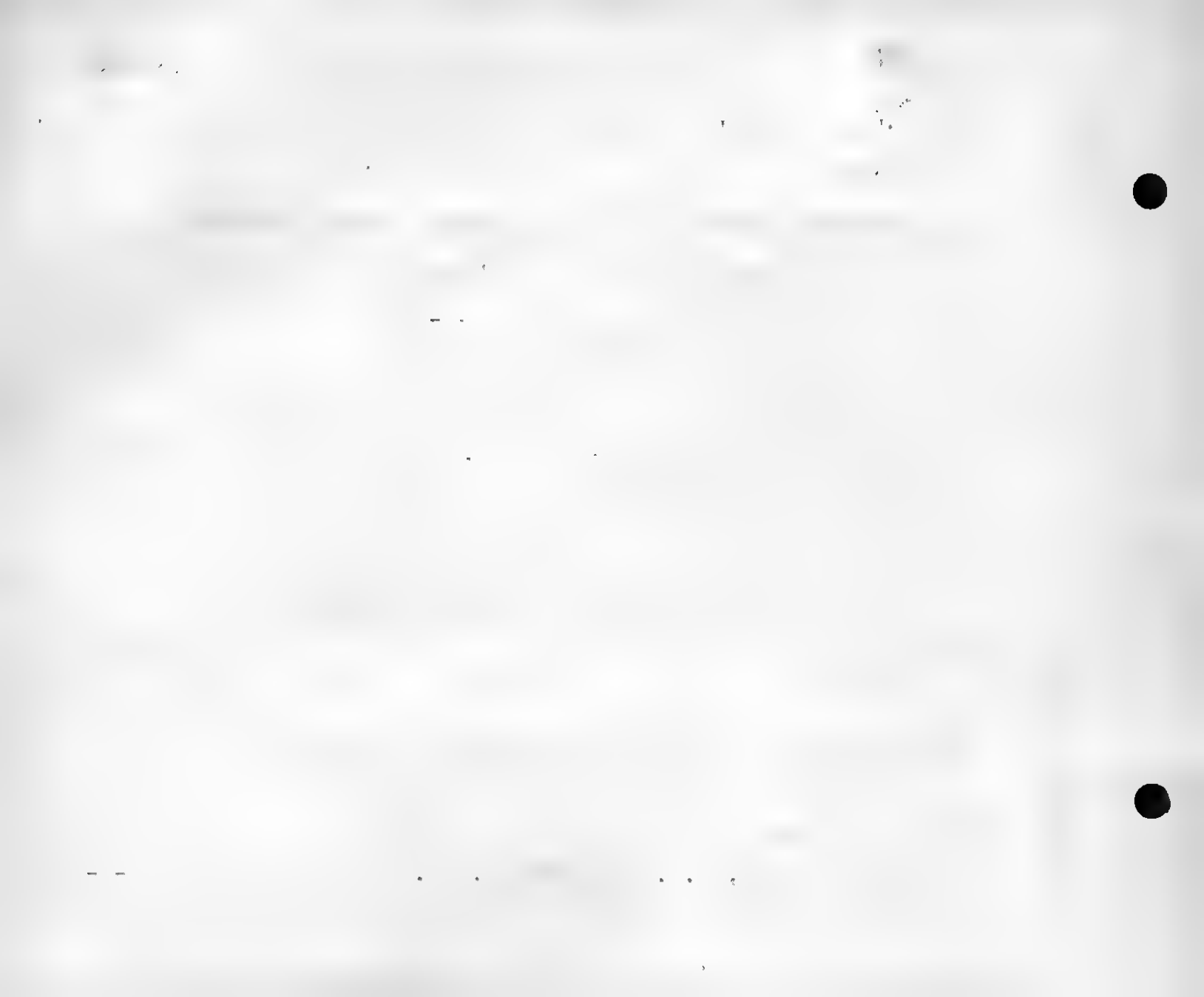
Items 18-21 Film 387 4-1 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01149

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01148

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				c. LENGTH OF STAY IN 1b <b>11-1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>811 Somerset Street</b>				d. STREET ADDRESS <b>811 Somerset Street</b>			
3. NAME OF DECEASED (Type or print) <b>Rose Immaculate D'Amico</b>				4. DATE OF DEATH Month <b>1</b> Day <b>2</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-4-1904</b>	9. AGE (In years last birthday) yrs <b>62</b>	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Gaetono Tassa</b>				14. MOTHER'S MAIDEN NAME <b>Adelaide Bocchino</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO <b>578-14-1623</b>		17. INFORMANT <b>Mr. Desio T. D'Amico (above address)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: <b>9702</b> IMMEDIATE CAUSE (a) <b>Barbiturate intoxication</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Ingested overdose of barbiturates</b>				
20c. TIME OF INJURY Month, Day, Year Hour o m <b>10:30-PM 1 2 19 67</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) <b>Home</b>	20f. (City or town) <b>Hyattsville</b>	(County) <b>Pr. Geo.</b>	(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>			22. DATE SIGNED <b>1-3-67</b>				
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>			23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				
23b. DATE THEREOF <b>1/5/67</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>			23d. LOCATION (City or town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>Nalley's Home Inc.</b>			ADDRESS <b>Mt. Rainier Maryland</b>			25a. REC'D BY REG-STRAR <b>DATA 9 1967</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01150				CERTIFICATE OF DEATH				01149			
1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 day				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 12319 Firtree Lane, Bowie, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN L. DAWSON				4. DATE OF DEATH Month Day Year 1 23 1967							
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 15, 1906		9. AGE (In years last birthday) 60 yrs.		10. FUNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Printer				11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John A. S. Dawson				14. MOTHER'S MAIDEN NAME Eva May Cox							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 578-05-4699				17. INFORMANT Address 6700 Belcrest Rd. Alan B. Dawson Hyattsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrhythmia</i> DUE TO (b) <i>Respiratory insufficiency</i> DUE TO (c) <i>Pneumonia</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Rheumatic heart disease, congestive heart failure</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1-22, 1967, to 1-23, 1967, that (I) (we) last saw the deceased alive on 1-22, 1967, and that death occurred at 12:22 PM, from the causes and on the date stated above.											
22a. SIGNATURE <i>Fidel J. Quintana</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 1-23-67			
22c. PHYSICIAN'S NAME (Type) FIDEL J. QUINTANA				22d. ADDRESS 12004 MAYCHECK LA, BOWIE, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1/26/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Colmar Manor Md.			
24. FUNERAL DIRECTOR J. Wm. Lees Sons; Wash., DC				ADDRESS				25a. REC'D BY REGISTRAR JAN 26 1967		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01151

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01150

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>5221 Walnut Lane</b>	
3. NAME OF DECEASED (Type or print) <b>Frances R Deakins</b>		4. DATE OF DEATH Month <b>1</b> Day <b>19</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-26-1922</b>
9. AGE (In years last birthday) <b>44</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>waitrees</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward J. Byrnes</b>		14. MOTHER'S MAIDEN NAME <b>Margaret T. Reiter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>NO</b>	
17. INFORMANT <b>Ellsworth I. Deakins</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. <b>816.4</b> IMMEDIATE CAUSE (a) <b>Left epidural hemorrhage and right subdural hemorrhage</b> DUE TO (b) <b>From brain lacerations</b> DUE TO (c) <b>From skull fractures, basalar and left parietal</b> FROM <b>trauma auto accident.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger of car involved in collision.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>1:10 a.m.</b> <b>1-16-1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.) <b>Morningside, Maryland</b>		20f. (City or town) (County) (State) <b>Suitland Rd. &amp; Ridge Crest Drive</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>1-20-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/23/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b>		25a. RECD BY REG STRAR <b>JAN 23 1967</b>	
Address <b>4308 Suitland Rd. Suitland, Md.</b>		25b. REG STRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

01152

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01151

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chillum</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>711 Rittenhouse Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Marriott Clifton Deck DICK</b>				4 DATE OF DEATH Month <b>1</b> Day <b>24</b> Year <b>19 67</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>21 Jan. 1884</b>	9 AGE (in years last birthday) <b>83 yrs</b>	10 UNDER 1 Year Months <b>24</b> Days <b>19</b> Hours <b>67</b>	11 OVER 24 HRS Months <b>24</b> Days <b>19</b> Hours <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer-Timber Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Same (Ret.)</b>		11 BIRTHPLACE (State or foreign country) <b>New Wilmington, Pa.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Dick</b>				14. MOTHER'S MAIDEN NAME <b>Lavina Stewart</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>181 28 3109</b>		17. INFORMANT Address <b>Mrs. Sadie C. Dick, (same as #2).</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>unknown</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONNOTED IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>				22. DATE SIGNED <b>1-24-67</b>			
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>Jan. 27. 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hickrist Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Sharon, Penna</b>	
24. FUNERAL DIRECTOR <b>Arthur Walters, 254 Carroll St. NW. Wash. D.C.</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 26 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01153					01152				
1. PLACE OF DEATH a. COUNTY Prince George's County, MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland p. COUNTY Prince George's				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 5 hrs.15 mins.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenbelt				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital					d. STREET ADDRESS 60-B Crescent Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FLOYD Middle IRVING Last DIXON			4. DATE OF DEATH Month Jan. 11, Year 1967						
5. SEX Male		6. COLOR White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/3/1900		9. AGE (In years last birthday) 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dept. of Agr.			10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (County & State, or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Dixon					14. MOTHER'S MAIDEN NAME ? Pettit				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. (If yes give war or dates of service) 247 05 3853		17. INFORMANT Address Virginia A. Dixon Same as #2 (wife)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage - left internal capsule 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis - marked DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from March 1963, to Jan. 11, 1967, that (I) (we) last saw the deceased alive on Jan. 11, 1967, and that death occurred at 1:20 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Till Bergemann, M. D.					22b. DATE SIGNED P.M.			22c. PHYSICIAN'S NAME (Type) Till Bergemann, M. D.	
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) Buried					23b. DATE THEREOF 1/14/67		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Mem. Gardens		
24. FUNERAL DIRECTOR Francis Gasch's Sons					ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JAN 16 1967		
							25b. REGISTRAR'S SIGNATURE John Jones		

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142

142



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01154

## CERTIFICATE OF DEATH

01153

1 PLACE OF DEATH a COUNTY <b>PRINCE GEORGE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7520 TEMPLE HILL ROAD</b>		d. STREET ADDRESS <b>7520 TEMPLE HILL ROAD</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>ONEIDA J. DRIGGERS</b>		4 DATE OF DEATH Month Day Year <b>JANUARY 6 19 67</b>	
5 SEX <b>FEMALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>APRIL 24, 1920</b>
9 AGE (In years last birthday) yrs <b>46</b>		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM DAMERON</b>		14. MOTHER'S MAIDEN NAME <b>FLOSSIE GRIZZEL</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO.	
17. INFORMANT <b>HEZEKIAH DRIGGERS SAME AS 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>104X</b> IMMEDIATE CAUSE (a) <b>Spontaneous Metastatic Carcinoma</b> DUE TO (b) <b>Carcinoma of Kidney</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b> <b>7 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 6, 1966</b> to <b>Jan 6, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan 6, 1967</b> , and that death occurred at <b>10:55 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>1-7-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b>		22d. ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>JAN. 10, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, VIRGINIA</b>
24 FUNERAL DIRECTOR <b>WILHELM FUNERAL HOME</b> ADDRESS <b>4308 SUITLAND ROAD, SUITLAND, MD.</b>		25a REC'D BY REGISTRAR DATE <b>10 1967</b>	
		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>	



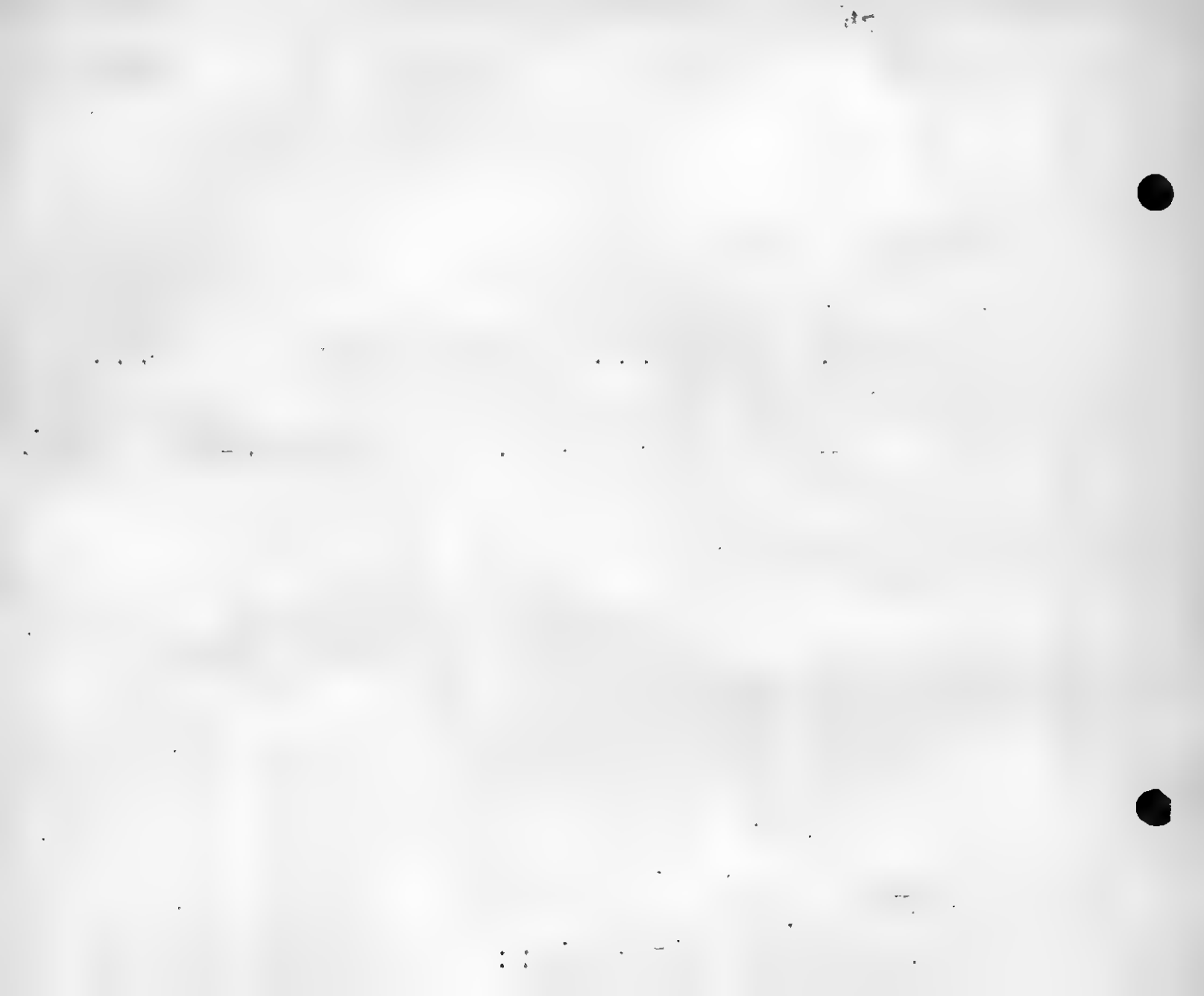
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>1 (M)</p> <p>01155</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p><b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b></p> </div> <div> <p>01154</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY Prince George's				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b PCA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ieland Memorial Hospital				d. STREET ADDRESS 6313 Callatin Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Dudley		First Dudley		Middle Parkerson		Last Dungan		4. DATE OF DEATH 1 20 1967		Month Day Year	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3-29-14		9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR: Months Days Hours Mln. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Metro. Policeman-Wash. D.C.				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Lodge, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Garrett Alexander Dungan				14. MOTHER'S MAIDEN NAME Elizabeth Merle Dungan				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. Not Available				17. INFORMANT Mrs. Frances Garrison (Sis.)				Address 10500 Royal Rd. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic Heart Disease DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John Meloe M.D.				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED 1-1-67			
EXAMINER'S NAME (Type) John Meloe M.D., Riverdale, Maryland				Address (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL, OR OTHER BURIAL				23b. DATE THEREOF Jan. 24/67		23c. NAME OF CEMETERY OR CREMATORY Melrose Cemetery		23d. LOCATION (City, town or county) (State) Callao, Virginia			
24. FUNERAL DIRECTOR Hysong Funeral Home Per: Thomas M. Hysong				ADDRESS 1300 N Street N.W. Washington, D.C.				25a. REC'D BY REGISTRAR DATE JAN 24 1967			
				25b. REGISTRAR'S SIGNATURE Charles Judge							

MEDICAL CERTIFICATION



01156

CERTIFICATE OF DEATH

01155

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN lb <b>Four months</b>		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Home</b>				d. STREET ADDRESS <b>10009 Belhaven Road</b>	
3 NAME OF DECEASED (Type or print) <b>Cecelia</b>		First Middle Last <b>Durkin</b>		4 DATE OF DEATH Month Day Year <b>January 11 1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>April 13, 1880</b>		9 AGE (In years last birthday) <b>87 86 yrs</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerical</b>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>Chicago, Illinois</b>	
12 CITIZEN OF WHAT COUNTRY? <b>United States</b>			13 FATHER'S NAME <b>Hugh Coyle</b>		
14 MOTHER'S MAIDEN NAME <b>Theresa Quinlan</b>			15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		
16 SOCIAL SECURITY NO <b>213-50-2972</b>		17. INFORMANT Address <b>Sacred Heart Home, Hyattsville, Maryland</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. <b>442X Chronic Cardio-Vascular</b> <b>hypertension - sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 months</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>15 Sept 66</b>	
20f (City or town) <b>10 Jan 67</b>		20g (County) <b>Sp</b>		20h (State) <b>19</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>15 Sept 66</b> to <b>10 Jan 67</b> , that (I) (we) last saw the deceased alive on <b>10 Jan 1967</b> , and that death occurred at <b>3p</b> M, from causes and on the date stated above.					
22a SIGNATURE <b>Robert C. Haile</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b ADDRESS <b>Jan 11 67</b>	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>1/14/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Assumption Cemetery</b>	
23d LOCATION (City or Town) <b>Glenwood, Ill.</b>		23e REC'D BY REGISTRAR <b>Charles Judge</b>		23f REGISTRAR'S SIGNATURE <b>Jan 17 1967</b>	
24 FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc. Maryland</b>					



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VR A15 (4)  
20 M 1/66

1 (M)

01157

CERTIFICATE OF DEATH

01156

1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beaver Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 5309 Nash Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Cora C. Farmer		4. DATE OF DEATH Month Day Year January 13, 19 67	
5 SEX Female	6 COLOR OR RACE Colored	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 9/16/99
9 AGE (In years last birthday) 67 yrs		10. IF UNDER 1 Year Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William White		14. MOTHER'S MAIDEN NAME Frances Brodgan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Frances Wilkins Fairmont Heights		1000 <sup>Address</sup> 59th Ave.,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular Thrombosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus - Vascular Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 31, 1966, to Jan. 13, 1967, that (I) (we) last saw the deceased alive on Jan. 13, 1967, and that death occurred at 5:20 M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edwin J. Jensen</u> M.D.		22b. DATE SIGNED 1/14/67	
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen		22d. ADDRESS Prince George's General Hospital, Cheverly, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-17-67	
23c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery		23d. LOCATION (City or Town) (County) (State) Lanover, Md.	
24. FUNERAL DIRECTOR Rallis 4339 - Hunt PL-NS		25a. REC'D BY REGISTRAR DATE JAN 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			





01158

CERTIFICATE OF DEATH

01157

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville,	
c. LENGTH OF STAY in ib 17 days		d. STREET ADDRESS 7622 Greeley Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Carrie M Farrar		4 DATE OF DEATH Jan. 26 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1879
9 AGE (In years last birthday) 87 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11 BIRTHPLACE (County & State, or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Archelus D. McCobb		14. MOTHER'S MAIDEN NAME Caroline F. Witney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO	
17. INFORMANT Lydia F. Steward		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperextension Spine</u> DUE TO <u>Dissecting Aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>a Cerebro Vascular Accident on 1/19/67</u> (b) <u>Dissecting Aneurysm</u> DUE TO <u>Cerebro Vascular Accident on 1/19/67</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/9</u> , 1967, to <u>1/26</u> , 1967 that (I) (we) last saw the deceased alive on <u>1/26</u> 1967, and that death occurred at <u>2:35 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Benjamin S. Miller</u> M.D.		22b. DATE SIGNED <u>1/26/67</u>	
22c. PHYSICIAN'S NAME (Type) Benjamin S. Miller, M.C.		22d. ADDRESS 3824 34th St. Mt. Rainier, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-30-67	23c. NAME OF CEMETERY OR CREMATORY Brooklawn Cemetery	23d. LOCATION (City or Town) (County) (State) Portland, Maine
24. FUNERAL DIRECTOR Lee Funeral Home 300 4th St. N.E. Wash., D.C.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01159

01158

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Washington, DC</b> b. COUNTY <b>Washington, DC</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Forestville, Md.</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington, DC</b>			
c. LENGTH OF STAY IN 1b <b>14- Months</b>				d. STREET ADDRESS <b>226- 5th Street SE.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Forestville Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>L.</b> Last <b>FARRELL</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>4th</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>August 4th 1884</b>	9. AGE (in years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>17</b> Hours <b>2</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DO. Transit</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Farrell</b>				14. MOTHER'S MAIDEN NAME <b>Dalvenia Russell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Robert J. Farrell ( Son )</b>		Address <b>La Plata Md. Box. 633</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory Collapse</b> DUE TO (b) <b>Pneumonia</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Pyelonephritis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>2 days</b> <b>3 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 27, 1965</b> to <b>Jan 4, 1967</b> that (I) (we) last saw the deceased alive on <b>1/3/67</b> and that death occurred <b>1/4/67</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Kevin L. Minchin</b>				22b. DATE SIGNED <b>1/4/67</b>		22c. PHYSICIAN'S NAME (Typed) <b>KEVIN L MINCHIN</b>	
22d. ADDRESS <b>6400 MARLBOROUGH</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 7th-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR <b>Simmons Bros. Funeral Home</b>		ADDRESS <b>1661-Gd. Hope Rd. SE</b>		25a. REC'D BY REGISTRAR <b>JAN 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01160

01159

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-UPPER MARLBORO c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) JUNCTION OF CROOM STATION ROAD AND CROOMS ROAD, UPPER MARLBORO		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXON HILL d. STREET ADDRESS 9522 CHALFONT AVENUE	
3. NAME OF DECEASED (Type or print) First Middle Last GUY WALTER FETHERSTON		4. DATE OF DEATH Month Day Year JANUARY 8 1967	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 NOV 32
9. AGE (In years last birthday) 34 yrs.		10. FUND 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENLISTED MAN		10b. KIND OF BUSINESS OR INDUSTRY USNR-R	
11. BIRTHPLACE (State or foreign country) NEW YORK, NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WALTER LAW FETHERSTON		14. MOTHER'S MAIDEN NAME ELENOR JOSEPHINE (UNKNOWN)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 54-56 61-62		16. SOCIAL SECURITY NO. 477-46-0262	
17. INFORMANT OFFICIAL U.S. NAVY RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INJURIES MULTIPLE EXTREME DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AIRCRAFT ACCIDENT 20c. TIME OF INJURY Month, Day, Year 1107 8 JAN 1967 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) FARM 20f. (City or town) (County) (State) NEAR UPPER MARLBORO, MD.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JOHN KEHOE, MD		22. DATE SIGNED 9 JAN 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-13-67	
23c. NAME OF CEMETERY OR CREMATORY Arlington Hall Cem		23d. LOCATION (City, town or county) (State) Ft Belvoir Va.	
24. FUNERAL DIRECTOR W.W. Chambers Co 1400 Chapin Wash D.C.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE J Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



01161

## CERTIFICATE OF DEATH

01160

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AFB</b> c. LENGTH OF STAY IN 1b <b>ANDREWS AIR FORCE BASE</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> d. STREET ADDRESS <b>3849-3 MICHIGAN AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LOVELL STEPHEN FISHER</b> First Middle Last		4. DATE OF DEATH Month Day Year <b>JANUARY 26 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>24 JAN 1925</b>
9. AGE (In years last birthday) <b>42 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>26 1967</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SERGEANT E-8 USMC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. MARINE CORPS</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>EVERETT, WASHINGTON</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DECEASED</b>		14. MOTHER'S MAIDEN NAME <b>TREVA LA MOSS HAYDEN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES 1944-Present</b>		16. SOCIAL SECURITY NO. <b>506-20-4757</b>	
17. INFORMANT <b>OFFICIAL U.S. MARINE CORPS RECORDS</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROSIS GENERALIZED</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CORONARY THROMBOSIS</b> DUE TO (c) <b>MYOCARDIAL INFARCTION</b>			INTERVAL BETWEEN ONSET AND DEATH <b>YEARS 1 DAY</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <del>this hospital</del> attended the deceased from <b>26 JAN 1967</b> , to <b>26 JAN 1967</b> , that (I) <del>was</del> saw the deceased alive on <b>26 JAN 1967</b> , and that death occurred at <b>11:03 M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>JAY F. KENT, M.D.</b> 22c. PHYSICIAN'S NAME (Type) <b>JAY F. KENT, LT. USN, MC</b>		22b. DATE SIGNED <b>26 JAN 67</b> 22d. ADDRESS <b>NAVAL MEDICAL DEPARTMENT, NAVAL AIR FACILITY, ANDREWS AFB, WASH DC 20331</b>	
23a. BURIAL (CREMATION, REMOVAL) (Specify) <b>1/28/67</b>	23b. DATE THEREOF <b>1/28/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lady of Lourdes</b>	23d. LOCATION (City or town) (County) (State) <b>SALT LAKE CITY, UTAH</b>
24. FUNERAL DIRECTOR <b>W. H. Chandler, Jr.</b>		25a. REC'D BY REGISTRAR <b>1400 Chapin St NW</b>	25b. REGISTRAR'S SIGNATURE <b>30 1967</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





01162

## CERTIFICATE OF DEATH

01161

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>4 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>6221 Sligo Creek Pkwy.</b>	
3. NAME OF DECEASED (Type or print) <b>Lotta M Foss</b>		4. DATE OF DEATH <b>Jan. 22 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 Aug. 1876</b>
9. AGE (In years last birthday) <b>90 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Amos B Bond</b>		14. MOTHER'S MAIDEN NAME <b>Marcia Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Marion L. Johnson</b>		Address <b>Rockville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Tamponade</b> DUE TO <b>Ruptured Myocardium</b> (b) <b>Myocardial Infarction</b> DUE TO <b>Obstructive Pulmonary Disease</b> (c) <b>Ascending Coronary artery</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1-19 1967</b> to <b>1-22 1967</b> , that (I) <del>was</del> last saw the deceased alive on <b>1-22 1967</b> , and that death occurred at <b>2:00 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Irvin M. Grassgreen</b>		22b. DATE SIGNED <b>1-23-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>IRVIN M. GRASSGREEN M.D.</b>		22d. ADDRESS <b>MT. RAINIER, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan 25, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland Pro Geo Md.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>JAN 26 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH					
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
01163		CERTIFICATE OF DEATH		01162	
1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b> c. LENGTH OF STAY IN 1b <b>4 yrs., 7 mos.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1308 14th Street N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>Nathaniel Foster</b>		4 DATE OF DEATH Month <b>Jan.</b> Day <b>25</b> Year <b>1967</b>			
5 SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>9/9/1922</b>	9. AGE (In years last birthday) <b>44</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Houseman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kenwood Country Club</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Ashville, N. C.</b>	
13. FATHER'S NAME <b>Clarence Foster</b>		14. MOTHER'S MAIDEN NAME <b>Ida Mae Johnson</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>679-18-8048</b>		17. INFORMANT <b>Decedent</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>(1) Bronchopneumonia; (2) from peptic ulcer</b> DUE TO (b) <b>status post uretero-ileostomy</b> (c) <b>paraplegia, level of D2 secondary to gunshot wound of the spine</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>12 days</b> <b>6 yrs. 2 mo.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>rheumatic heart disease with mitral stenosis, compensated; acute bacterial endocarditis, 1/66, healed</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6/25</b> <b>1967</b> to <b>1/25</b> , 1967, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>1/25</b> <b>1967</b> , and that death occurred at <b>10:30 P</b> M, from causes and on the date stated above.		22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>1/25/1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-2-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Mem. Park</b>	
23d. LOCATION (City or Town) (County) (State) <b>Landover, Maryland</b>		24. FUNERAL DIRECTOR <b>Rollins 4339 Hunt Rd N.E.</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 1 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



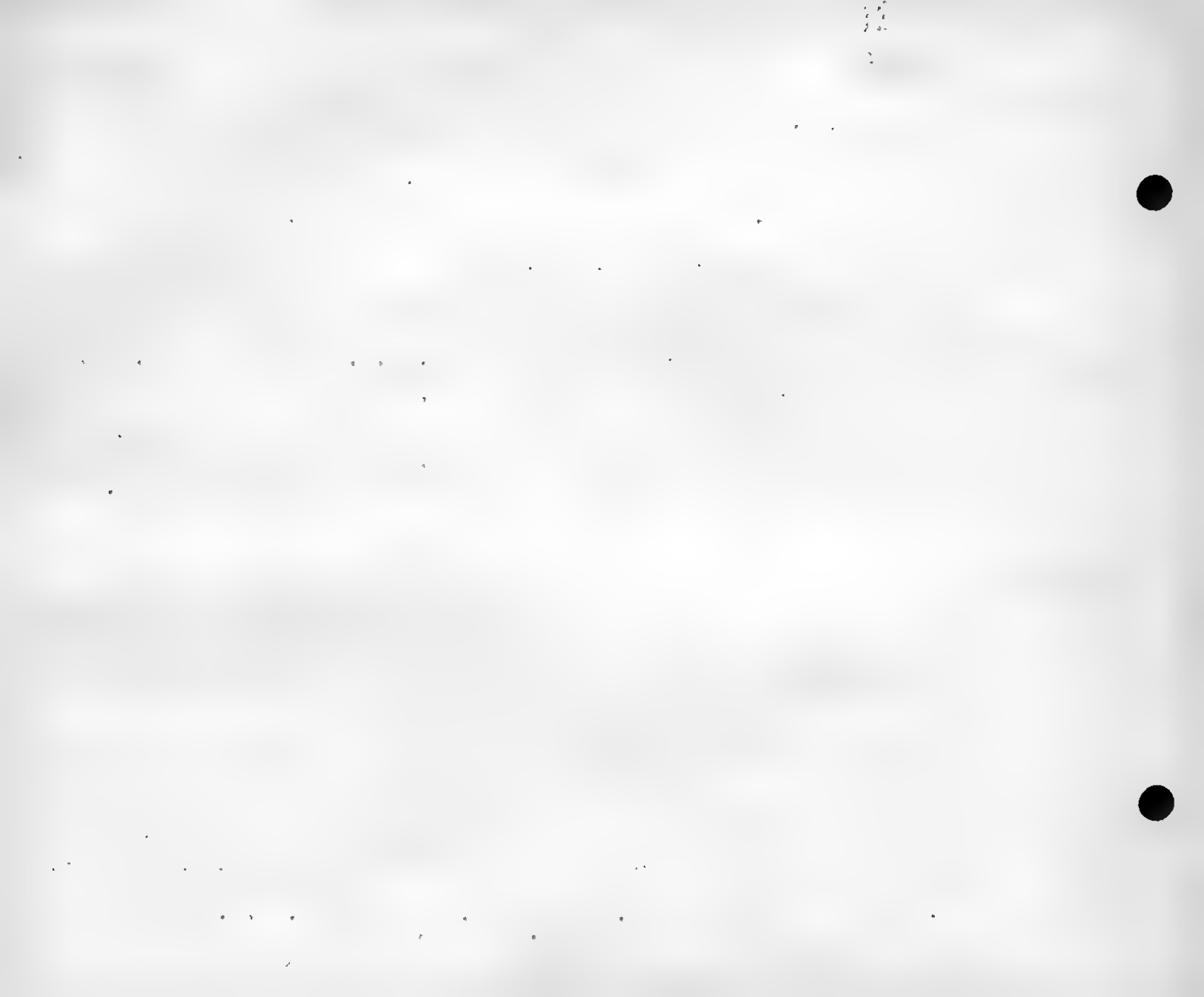
01164

CERTIFICATE OF DEATH

01163

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>3204 Chillum Rd.</b>	
3 NAME OF DECEASED (Type or print) <b>William J. Fraber</b>		4. DATE OF DEATH Month <b>January</b> Day <b>26</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1887</b> <b>Sept. 14, 1887</b>
9. AGE (In years last birthday) <b>79 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Wash., D.C.</b>	
13. FATHER'S NAME <b>John Fraber</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-97-3107A</b>	
17. INFORMANT <b>Mrs. Margaret Stafford Mills</b>		Address <b>9280 - Johns</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> DUE TO (b) <b>Pulmonary Edema, severe, bilateral</b> DUE TO (c) <b>Emphysema</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , 19 to <b>11/26</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11/26/66</b> , and that death occurred at <b>1255 P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Leon Levitsky, M.D.</b>		22b. DATE SIGNED <b>Jan. 26, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Leon Levitsky, M.D.</b>		22d. ADDRESS <b>3408 Rhode Island Ave. Mt. Rainier, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/30/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Wash., D.C.</b>
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 1 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. J. J. Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #2b File # 3381 1/11/67 pc

01165

CERTIFICATE OF DEATH

01164

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchton	
c. LENGTH OF STAY IN lb 1 day		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital	
d. STREET ADDRESS Great Oak Parkway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harry John Franklin		4. DATE OF DEATH Month Day Year Jan. 5, 19 67	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-29-1888
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCC. PAT ON (Give kind of work done during most of working life, even if retired) carpenter		12. KIND OF BUSINESS OR INDUSTRY Charles Co., Md.	
13. BIRTHPLACE (County & State, or foreign country) USA		14. CITIZEN OF WHAT COUNTRY? USA	
15. FATHER'S NAME John A. Franklin		16. MOTHER'S MAIDEN NAME Charollet Welch	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		18. SOCIAL SECURITY NO. 216-16-0501	
19. INFORMANT Patient/Medical Records		Address	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO CEREBRO-VASCULAR ACCIDENT (b) GEN ARTERIOSCLEROSIS (c) DUE TO UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		22b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22d. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-4, 19 67, to 1-5, 19 67, that (I) (we) last saw the deceased alive on 1-5, 19 67, and that death occurred at 8:05 A.M. from causes and on the date stated above.			
22a. SIGNATURE C J Holmann		22b. DATE SIGNED 1-5-67	
22c. PHYSICIAN'S NAME (Type) C J HOLMANN		22d. ADDRESS RIVERDALE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 1-11-67	
23c. NAME OF CEMETERY OR CREMATORY Memorial Baptist		23d. LOCATION (City or Town) (County) (State) Chesapeake Md	
24. FUNERAL DIRECTOR Hunt Funeral Home, Waldorf, Md		25a. REC'D BY REGISTRAR DATE JAN 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01166

## CERTIFICATE OF DEATH

01165

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Maryland Gardens Nursing Home</u>				d. STREET ADDRESS <u>2601 Oregon Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>Lester</u> First <u>E</u> Middle <u>F</u> Last <u>Frazier</u>				4. DATE OF DEATH Month <u>1</u> Day <u>22</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17, 1896</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>5</u>	IF UNDER 24 HRS Hours <u>4</u> Min <u>5</u>	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Buildings</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Charles E. Frazier</u>				14. MOTHER'S MAIDEN NAME <u>Addie V. Raines</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-16-2895</u>		17. INFORMANT Address <u>Earle E. Frazier Same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> <u>141.9</u> DUE TO <u>CC-2 Narcosis due to Respiratory</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Terminal Metastatic Carcinoma, Primary of Tongue</u> (b) <u>Respiratory</u> (c) <u>Terminal Metastatic Carcinoma, Primary of Tongue</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/6</u> , 19 <u>67</u> , to <u>1/22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/22</u> , 19 <u>67</u> , and that death occurred at <u>11:45</u> PM, from causes and on the date stated above							
22a. SIGNATURE <u>R. Longoria M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-22-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. Longoria, M.D.</u>				22d. ADDRESS <u>5813 Landover Rd. Hyattsville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/25/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor P.G. Md.</u>	
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons Hyattsville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

01167

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01166

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. STREET ADDRESS 5313 Crittenden St.	
3. NAME OF DECEASED (Type or print) First Middle Last Patricia Ann Furlong		4. DATE OF DEATH Month Day Year 1 24 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1929
9. AGE (n years last birthday) 37 yrs		10. F UNDER 1 YEAR Months Days 19 67	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME Glen Harvey Montgomery		14. MOTHER'S MAIDEN NAME Emma May Mauldin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 577 32 8853	
17. INFORMANT Gerald P Furlong		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Undetermined DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Associated with cerebral edema, Petechiae, (c) Chronic Pancreatitis, severe			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 1-26-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 30, 1967	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Virginia	
24. FUNERAL DIRECTOR Gasch's Sons		25a. ADDRESS Hyattsville, Md.	
25b. DATE BY REGISTRAR JAN 30 1967		25c. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



01168

CERTIFICATE OF DEATH

01167

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE, MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>5 YRS 9 MO</u>		d. STREET ADDRESS <u>1922 Basalt Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL MANOR</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>PIERRE LEON GADOL</u>		4 DATE OF DEATH Month Day Year <u>1 2 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-22-1889</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret red.) <u>ENGINEERING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GOVERNMENT</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PHOEBUS, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALPHONSE GADOL</u>		14. MOTHER'S MAIDEN NAME <u>MARY MAG DELIN DE COMPT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>068-03-0355</u>	
17. INFORMANT <u>Pierre A. Gadol</u>		Address <u>6306 Cheswood Pl. Lanham, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROTIC HEART DISEASE</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS</u> <u>1 YR</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 14, 1964</u> , to <u>JAN</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>DEC 29</u> 19 <u>66</u> , and that death occurred at <u>4:28</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>DR LEO I DOMINIAN</u>		22b. DATE SIGNED <u>1/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR LEO I DOMINIAN</u>		22d. ADDRESS <u>3218 Wisconsin Ave BETHESDA MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 6, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Hampton, Virginia</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Purphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>DATE Jan 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



01169

## CERTIFICATE OF DEATH

01168

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>WASHINGTON</b> b. COUNTY <b>D.C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BRANDYWINE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> <b>47.3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BOX 58 MARYLAND # 3</b>		d. STREET ADDRESS <b>239 ROCK CREEK CHURCH ROAD</b>	
3 NAME OF DECEASED (Type or print) <b>IDA M GARRISON</b>		4 DATE OF DEATH Month <b>1</b> Day <b>1</b> Year <b>1967</b>	
5 SEX <b>FEMALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>OCT. 24, 1868</b>
9 AGE (In years last birthday) <b>98</b> yrs		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>TERRANCE SIMS</b>		14. MOTHER'S MAIDEN NAME <b>RACHAEL WAYNE</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>ORA CARDIN 509 DENNIS AVE. MARYLAND</b>		Address <b>SIL. SPG.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE RESPIRATORY DISEASE</b> DUE TO <b>ARTERIOSCLEROSIS - POST CVA</b> (b) <b>GENERAL VISCERAL FAILURE</b> DUE TO <b>GENEAL VISCERAL FAILURE</b> (c) <b>GENEAL VISCERAL FAILURE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>4 DAYS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>PULMONARY EDEMA. ANURIA.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12/30</b> , 19 <b>66</b> , to <b>1-1</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1/1</b> , 19 <b>67</b> , and that death occurred at <b>2:40 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Robert W. Merkle M.D.</b>		22b. DATE SIGNED <b>1/1/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT W. MERKLE</b>		22d. ADDRESS <b>WALDORF, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>JAN. 4, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>PRINCE GEORGES, MARYLAND</b>
24 FUNERAL DIRECTOR <b>WILHELM FUNERAL HOME</b> 4308 SUITLAND ROAD, SUITLAND MD.		25a. REC'D BY REGISTRAR DATE <b>JAN 4 1967</b>	
25b. REGISTRAR'S SIGNATURE			





CERTIFICATE OF DEATH

01170

01169

1 PLACE OF DEATH a COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE D.C. b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c LENGTH OF STAY IN lb 78 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e STREET ADDRESS 1436 A St., S.E.	
3 NAME OF DECEASED (Type or print) Addie		4 DATE OF DEATH January 21, 19 67	
5 SEX female	6 COLOR OR RACE negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1/20/1899
9 AGE (In years last birthday) 68 yrs		10 IF UNDER 1 YEAR Months Days	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b KIND OF BUSINESS OR INDUSTRY -----	
11 BIRTHPLACE (County & State, or foreign country) South Carolina		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Alex Whitfield		14 MOTHER'S MAIDEN NAME Rectine Coronus	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 248-66-7468	
17 INFORMANT Decedent		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH CAUSED BY IMMEDIATE CAUSE (a) 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)		Probable bronchogenic carcinoma, right, with metastases and pleural effusion. 2 months	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, minimal; generalized arteriosclerosis with arteriosclerotic heart disease; diabetes mellitus		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from 11/4/1966, to 1/21/1967, that (we) last saw the deceased alive on 1/21/1967, and that death occurred at 5:00 P.M. from causes and on the date stated above.			
22a SIGNATURE Moe Weiss		22b DATE SIGNED 1/21/67	
22c PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d ADDRESS Glenn Dale Hospital Glenn Dale, Maryland	
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE THEREOF	
23c NAME OF CEMETERY OR CREMATORY Salem		23d LOCATION (City or Town) (County) (State) Salem, Charles County	
24 FUNERAL DIRECTOR National Funeral Home 412 Hat St		25a REC'D BY REGISTRAR DATE JAN 30 1967	
25b REGISTRAR'S SIGNATURE E.T. Murray			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01177

# CERTIFICATE OF DEATH

01170

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>PRINCE GEORGE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>		c. LENGTH OF STAY IN US <b>2 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>		16. 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CARROLL MANOR</b>				d. STREET ADDRESS <b>60042<sup>nd</sup> AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY A GAGGINS</b>				4. DATE OF DEATH Month Day Year <b>1 7 1967</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-15-1885</b>	9. AGE (In years last birthday) <b>81</b> yrs.	10. IF UNDER 1 Year Months Days Hours Min.		11. IF UNDER 24 HRS Hours Min.
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOHN LORING</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE MURTH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-549-404</b>		17. INFORMANT <b>Dr. James CARROLL MANOR</b>			
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>428.0 Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Gen. Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							INTERVA. BETWEEN ONSET AND DEATH <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>June 1, 1967</b> to <b>June 6, 1967</b> , that (1) (we) last saw the deceased alive on <b>June 6, 1967</b> , and that death occurred at <b>2:30</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>John D. Herman</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Jan 7, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>John D. Herman</b>				22d. ADDRESS <b>4801 Montgomery Lane, Bethesda, Md.</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-10-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT OLIVET CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON, D. C.</b>	
24. FUNERAL DIRECTOR <b>F. J. Collins</b>		ADDRESS <b>WASH. D.C.</b>		25a. REC'D BY REGISTRAR <b>JAN 10 1967</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	
FRANCIS J. COLLINS 3821 14th. ST. N.W.							



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8, Telephone call - Gasch's Funeral Home - 1/16/67

01172

## CERTIFICATE OF DEATH

01171

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and up any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's 4408 Queensbury Rd., Riverdale, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland, P.G. County College Park.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Maryland.	
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) Eugene Leland Hospital,		d. STREET ADDRESS 4603 Fordum Rd.	
3. NAME OF DECEASED (Type or print) First Sara Middle Eleanor Last Goodwin.		4. DATE OF DEATH Month January Day 10 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1914
9. AGE (In years last birthday) yrs 52		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Penn		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Harry H. Swainbank		14. MOTHER'S MAIDEN NAME Florence Wise	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 65-32-5062	
17. INFORMANT Hospital Records.		Address 4408 Queensbury Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO (b) <u>Cardiac arrest &amp; Stroke</u> DUE TO (c) <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>seconds</u> <u>2 days</u> <u>Months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of psychoneurosis</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/3, 1967</u> to <u>1/10, 1967</u> , that (I) (we) last saw the deceased alive on <u>1/10, 1967</u> , and that death occurred at <u>4:00 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Francis P. Chiarmonte</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>1/10/67</u>
22c. PHYSICIAN'S NAME (Type) FRANCIS P. CHIARMONTE		22d. ADDRESS <u>Maroon Heights, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/14/67	23c. NAME OF CEMETERY OR CREMATORY Crystal Lake	23d. LOCATION (City or Town) (County) (State) Gardner Mass
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JAN 16 1967	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



01173

CERTIFICATE OF DEATH

01173

1 PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Res. dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>P.G.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>11 hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospito, give street address) <b>Prince George General</b>		d. STREET ADDRESS <b>P.O. 65</b>	
3 NAME OF DECEASED (Type or print) First <b>Beulah</b> Middle <b>F.</b> Last <b>Gloss</b>		4 DATE OF DEATH Month <b>Jan</b> Day <b>7</b> Year <b>19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>6-8-84</b>
9 AGE (In years last birthday) yrs <b>82</b>		10a USUA. OCCUPATION (Give kind of work done during most of work ng life, even if retired) <b>HOUSEWIFE</b>	
10b KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11 BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>	
12 CIT ZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>AUGUSTUS FIGG</b>	
14 MOTHER'S MAIDEN NAME <b>LELIA TYREE</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16 SOCIAL SECURITY NO. <b>560 46 4222</b>		17 INFORMANT <b>MARGUERITE G. BENEDICT</b> Address <b>SAME AS #2</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-1</b> , 19 <b>66</b> to <b>1-7</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>Jan 7</b> 19 <b>67</b> , and that death occurred at <b>8:20 PM</b> causes and on the date stated above.			
22a. SIGNATURE <b>Aaron Deitz</b>		22b. DATE SIGNED <b>1-8-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Aaron Deitz</b>		22d. ADDRESS <b>Hyattsville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>9 JAN 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN</b>		23d. LOCATION (City or Town) (County) (State) <b>BLADENSBURG, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 12 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01174

CERTIFICATE OF DEATH

01174

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Pro Geo Md.</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>cheverly, Md</b>		c LENGTH OF STAY IN 1b <b>1 day</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's Hospital</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>George</b> First <b>G.</b> Middle <b>Gray</b> Last		4 DATE OF DEATH Month <b>Jan</b> Day <b>6</b> Year <b>1967</b>	
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Oct 25, 1907</b>
9 AGE (In years last birthday) <b>59</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Brick Co.</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13. FATHER'S NAME <b>George W Gray</b>		14 MOTHER'S MAIDEN NAME <b>Lillian Thompson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO. <b>579 164 611</b>	
17 INFORMANT <b>Joseph G Gray</b>		Address <b>Hyattsville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the larynx with metastases</b> DUE TO (b) <b>Understand</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1953</b> to <b>1-6, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan 6 1967</b> , and that death occurred at <b>9:42 M</b> , from causes and on the date stated above.			
22a SIGNATURE <b>Ronald S. Fleischer</b> M.D.		22b. DATE SIGNED <b>1-7-67</b>	
22c PHYSICIAN'S NAME (Type) <b>RONALD S. FLEISCHER, M.D.</b>		22d ADDRESS <b>7411 RIGGS Rd, Hyattsville, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan 9, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	23d. LOCATION (City or town) (County) (State) <b>Heaton Montgomery Md.</b>
24 FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>JAN 10 1967</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01175

CERTIFICATE OF DEATH

01175

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE b. COUNTY <b>Washington, D. C.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 1b <b>5 yr 1 mo</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>			d. STREET ADDRESS <b>1364 Newton St., N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Julia B. Green</b>			4. DATE OF DEATH Month Day Year <b>January 25, 1967</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/15/88</b>	9. AGE (In years last birthday) yrs <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Samuel Bailey</b>			14. MOTHER'S MAIDEN NAME <b>Julia ?</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>unknown</b>	17. INFORMANT <b>decendent</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Probable cerebrovascular accident</b> DUE TO (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>unknown</b> <b>unknown</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary tuberculosis</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/14/1962</b> , to <b>1/25/1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1/25/1967</b> , and that death occurred at <b>8:45AM</b> from causes and on the date stated above.					
22a. SIGNATURE <i>Moe Weiss</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>1/25/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22d. ADDRESS <b>Glenn Dale Hospital, Glenn Dale, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>1-28-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland Rd. Md.</b>		
24. FUNERAL DIRECTOR <i>E. J. Taylor</i>		ADDRESS <b>EDMONSON FUNERAL SERVICE 9096 ST. N.W.</b>	25a. REC'D BY REGISTRAR DATE <b>JAN 30 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

Body released by Mr. Kahoe - Page Corner

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01176											
01173											
Item 8 Film 6385 2/6/67											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Adelphi				c. LENGTH OF STAY IN ID 4-15-62				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Point Branch Nursing Home				d. STREET ADDRESS 114 Park Ave.				6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Cora M. Gregg				4. DATE OF DEATH Month 1 Day 30 Year 1967							
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1883 5-12-1914		9. AGE (In years last birthday) 8-3 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Montgomery		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James C Morris				14. MOTHER'S MAIDEN NAME Sarah Lowe							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-56-6967		17. INFORMANT Mary Wallace		Address 13015 Tamarack Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pul. embolus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Ch. Reg. Myocarditis 11/24/66 DUE TO (c) 1st urinary bleed - 1/14/67										INTERVAL BETWEEN ONSET AND DEATH sudden 22 yrs 17 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 5, 1967, to Jan 30, 1967, that (I) (we) last saw the deceased alive on 12/27/1966, and that death occurred at 4A M, from the causes and on the date stated above.											
22a. SIGNATURE Howard T. Morse				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 1/30/67			
22c. PHYSICIAN'S NAME (Type) Howard T Morse				22d. ADDRESS Carroll Ave. Tak PK, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Feb. 1, 1967		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town or county) (State) Washington D.C.			
24. FUNERAL DIRECTOR Arthur Walter - Washington, D.C.				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE J. Charles Judge		DATE FEB 2 1967			



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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01177

CERTIFICATE OF DEATH

01176

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>3HR 7MIN</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DISTRICT OF COLUMBIA</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BOLLING AIR FORCE BASE</b> d. STREET ADDRESS <b>135 GARRISON STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>PATRICIA</b>		First <b>(NONE)</b>		Middle <b>GUSKE</b>		Last <b>GUSKE</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>28</b> Year <b>19 67</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>28 JAN 1967</b>		9. AGE (In years last birthday) yrs. <b>7</b> IF UNDER 1 YEAR Months <b>3</b> Days <b>7</b> IF UNDER 24 HRS. Hours <b>3</b> Min. <b>7</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PRINCE GEORGE'S, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>RICHARD MAX GUSKE</b>				14. MOTHER'S MAIDEN NAME <b>JOYCE ELIZABETH BEAUREGARD</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>RICHARD M. GUSKE - FATHER - SAME AS #2</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Distress Syndrome</b> <b>1135</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Prematurity</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>3HR 7MIN</b> <b>3HR 7MIN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>28 Jan</b> , 19 <b>67</b> , to <b>28 Jan</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>28 Jan</b> , 19 <b>67</b> , and that death occurred at <b>6:33</b> P, from the causes and on the date stated above.									
22a. SIGNATURE <b>Paul H. Perlstein</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>28 Jan 67</b>			
22c. PHYSICIAN'S NAME (Type) <b>PAUL H. PERLSTEIN, CAPT, USAF, MC</b>				22d. ADDRESS <b>USAFB HOSPITAL ANDREWS</b> <b>ANDREWS AFB, WASHINGTON DC 20331</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 1, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington D. C.</b>			
24. FUNERAL DIRECTOR <b>Wilhelm Funeral</b> Home 4308 Suitland Road, Suitland Maryland				25a. REC'D BY REGISTRAR <b>FEB 2 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

X

X



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01178

## CERTIFICATE OF DEATH

01177

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>		
c. LENGTH OF STAY in 1b <b>2 days</b>			d. STREET ADDRESS <b>Magnolia Gardens</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>					
3. NAME OF DECEASED (Type or print) First <b>J.</b> Middle <b>Blaine</b> Last <b>Gwin</b>			4. DATE OF DEATH Month <b>January</b> Day <b>7</b> Year <b>19 67</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Jan 23, 1882</b>		9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Personal Director</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Red Cross</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Indiana</b>	
13. FATHER'S NAME <b>Jesse Chambers Gwin</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Wright</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>229 60 0876J1</b>		17. INFORMANT <b>Florence G Benton</b> Address <b>Lanham, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerotic heart disease</b> (c) <b>arteriosclerosis generalized</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>hypertension from long standing (thrombotic)</b>					INTERVAL BETWEEN ONSET AND DEATH <b>known</b> <b>3 years</b> <b>5 years</b>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March, 1966</b> , to <b>June 7, 1966</b> , that (I) (we) last saw the deceased alive on <b>June 7, 1966</b> ; and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Leon R. Levitsky, M.D.</b>		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Leon R. Levitsky, M.D.</b>		22d. ADDRESS <b>3408 Rhode Island Ave., Mt. Rainier, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 10, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>	
23d. LOCATION (City, town or county) <b>Culpeper Virginia</b>		(State)			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 11 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



01179

## CERTIFICATE OF DEATH

02560

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>P. G. Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY in lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Keloland Memorial</u>		d. STREET ADDRESS <u>3 Riverview Ct</u>	
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Girl</u> Last <u>Hall</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-27-67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	9. AGE (in years last birthday) yrs <u>6</u> Months <u>30</u> Days <u>30</u> Hours <u>30</u> Min
11. BIRTHPLACE (County & State or foreign country) <u>Riverdale, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Walker Hall</u>		14. MOTHER'S MAIDEN NAME <u>Brenda Jean Howell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>na</u>	17. INFORMANT <u>Harp Record</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Atelactasis</u> 7625 DUE TO (b) <u>Pneumonia 28 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>---</u>			INTERVAL BETWEEN ONSET AND DEATH <u>28</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/27</u> , 19 <u>67</u> , to <u>1/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/27</u> , 19 <u>67</u> , and that death occurred at <u>2:30 AM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Robert S. McCeney</u> M.D.		22b. DATE SIGNED <u>---</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert S. McCeney</u>		22d. ADDRESS <u>402 Fair Street, Laurel, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>January 31, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ivy Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Laurel, P. G. Md.</u>
24. FUNERAL DIRECTOR <u>Charles W. Wade, Laurel, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01180

## CERTIFICATE OF DEATH

01178

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>14 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>		d. STREET ADDRESS <b>6310 Foote St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Blanche</b> Middle <b>P.</b> Last <b>Hall</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>16</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>2/28/81</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tenant</b>	9. AGE (in years lost birthday) yrs <b>85</b>
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13 FATHER'S NAME <b>Daniel Pumphrey</b>		14 MOTHER'S MAIDEN NAME <b>Charlotte Cox</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>---</b>	
17. INFORMANT <b>Thomas I. Scanlon-Seat Pleasant, Md.</b>		Address <b>6310 Foote St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Recent Cerebrovascular Accident</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 2,</b> 1967, to <b>Jan. 16,</b> 1967, that (I) (we) last saw the deceased alive on <b>Jan. 16,</b> 1967, and that death occurred at <b>2:10 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Edwin J. Jensen</b>		22b. DATE SIGNED <b>Jan. 17, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/20/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Upper Marlboro Md.</b>
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>		25a. REC'D BY REGISTRAR <b>Jan 30 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
01181		01179	
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DCA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights 14	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 6003 Sheriff Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last John Thomas Hardy		4. DATE OF DEATH Month 1 Day 13 Year 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 April 1887
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Henry	
14. MOTHER'S MAIDEN NAME Julia Secgwick		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT Emory Henry Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kenoe, M.D., Riverdale		22. DATE SIGNED 1-14-67	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Jan. 21, 1967	23c. NAME OF CEMETERY OR CREMATORY Lincoln Park	23d. LOCATION (City or town) (County) (State) Rockville, Montg. Co.
24. FUNERAL DIRECTOR Robert L. Snouder	ADDRESS Rockville, Md.	25a. REC'D BY REGISTRAR DATE JAN 24 1967	25b. REGISTRAR'S SIGNATURE Charles Judge





FOR STATE  
HEALTH DEPT.

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VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01182

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01180

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		d. STREET ADDRESS <b>9520 50th. Place</b>	
3 NAME OF DECEASED (Type or print) <b>Raymond S Harbin</b>		4 DATE OF DEATH Month <b>1</b> Day <b>3</b> Year <b>67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 June 1920</b>
9 AGE (In years lost birthday) <b>46</b> Yrs		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Electrical Contractor</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Raymond S. Harbin</b>		14 MOTHER'S MAIDEN NAME <b>Eula L Hodge</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>248 12 5142</b>	
17. INFORMANT <b>Frances E. Harbin Same as #2 (wife)</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>unknown</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		22. DATE SIGNED <b>1-3-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, or other disposition <b>Burial</b>	23b. DATE THEREOF <b>1/6/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or town) (County) (State) <b>Arlington Arlington Va.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 5 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01183					01181						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Prince George's County MARYLAND					a. STATE Maryland Prince George's County						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Maryland					b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover						
c. LENGTH OF STAY IN 1b 14 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital					d. STREET ADDRESS 10221 Landover Rd. Box 2339, Upper Marlboro, Md.						
e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES											
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		Month Day Year			
Henry Harmel							January 5, 1967				
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	27, 1898		68 yrs.		Months Days		Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Tobacco Farmer			Farmer			New York State			U. S. A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
Gustav Harmel					Julia Lintz						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
No			577-26-8781		Earl Harmel (son)		Box 2339, Upper Marlboro, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease										2 yrs	
DUE TO (b) Anteroseptal Coronary Heart Disease										2 weeks	
DUE TO (c) Acute pulmonary embolism										2 weeks	
Pneumonia											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED?	
Pleural Effusion										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
19											
21. I certify that (I) (this hospital) attended the deceased from 12-22, 1966, to 1-5, 1967, that (I) (we) last saw the deceased alive on 1-4, 1967, and that death occurred at 9:30 AM, from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED					
Charles Savaryan						Jan. 5, 1967					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
CHARLES SAVARYAN						5813 LANDOVER RD. Cheverly					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
Burial			1/7/67		Cedar Hill Cemetery			Suitland Md.			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Ritchie Bros. Upper Marlboro, Md.						DATE JAN 13 1967		Charles Judge			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01184

01182

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>				d. STREET ADDRESS <u>4110 46th Place</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Duncan Harris</u>				4. DATE OF DEATH Month Day Year <u>1 13 1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-16-20</u>	9. AGE (In years last birthday) <u>46</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Returner</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Harris</u>				14. MOTHER'S MAIDEN NAME <u>Helen Chase</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Cloude Harris</u> Address <u>1218 Queen St NE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Stenosis of orifice of right and left coronary arteries</u> DUE TO (c) <u>Chronic Aortitis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>1-13-67</u> <u>XXXXXX</u>	
EXAMINER'S NAME (Type) <u>John Kehoe L.D., Riverdale, Maryland</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE THEREOF <u>1-17-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CARVER</u>		23d. LOCATION (City or Town) (County) (State) <u>Mundick Md</u>	
24. FUNERAL DIRECTOR <u>W.S. Washington &amp; Sons</u>		ADDRESS <u>4925 Denne Ave. N.E.</u>		25a. REC'D BY REG. STRAR <u>JAN 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

pp 2



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01183

FOR STATE  
HEALTH DEPT.

01185

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN (b) <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheltenham</b> d. STREET ADDRESS <b>Boys Village</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Joseph Harris</b>		4. DATE OF DEATH Month <b>1</b> Day <b>23</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5 May 1919</b>
9. AGE (In years last birthday) <b>47</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>	
11. BIRTHPLACE (State or foreign country) <b>Moroland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank J. Harris</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Fowler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes in WW 2</b>		16. SOC. A. SECURITY NO. <b>213057726</b>	
17. INFORMANT <b>Mrs Mary F. Pikla</b>		Address <b>Balto. 36, Md. 8922 Carlisle Ave.</b>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO <b>Laceration of right neck</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Driver of car which struck tree.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Entrance road to Boy's Village, Cheltenham.</b>	
20c. TIME OF INJURY Month, Day, Year hour a.m. <b>2:30 a.m. 1-23-1967</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Boys Village, Cheltenham.</b>	20f. (City or town) (County) (State) <b>Baltimore Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>1-23-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>1/26/67.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Baltimore Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 26 1967</b>	25b. REGISTRAR'S SIGNATURE <b>John Charles Jones</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





01186

## CERTIFICATE OF DEATH

01184

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b>		c. LENGTH OF STAY IN 1b <b>Brandywine</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pineview Gardens Nursing Home</b>		d. STREET ADDRESS <b>Box 71 Brandywine, Md</b>	
3. NAME OF DECEASED (Type or print) <b>MARIAN F. HATTON</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>1st</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 29-1890</b>
9. AGE (In years last birthday) <b>76 yrs</b>		10. IF UNDER 1 Year Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, DC</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George Pumphrey</b>		14. MOTHER'S MAIDEN NAME <b>Louise ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Lyda E. Curtis Same as Item #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial infarction</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>2 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>DEC 28, 1966</b> , to <b>JAN 1, 1967</b> , that (I) (we) last saw the deceased alive on <b>DEC 31, 1966</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Paul A. DeVore</b>		22b. DATE SIGNED <b>Jan. 2nd 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Paul A. DeVore</b>		22d. ADDRESS <b>3415-KXX Hamilton St West Hyattsville Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 4-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Md.</b>
24. FUNERAL DIRECTOR <b>Simmons Bros.-1661-Good Hope Rd SE Wash DC</b>		25a. REC'D BY REGISTRAR <b>JAN 4 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

01187

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01185

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY in lb 40 min.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d STREET ADDRESS 12 Morris Drive	
3 NAME OF DECEASED (Type or print) Albert M. Hayes		4 DATE OF DEATH 1 10 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 21 May 1888 78 yrs
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		9b KIND OF BUSINESS OR INDUSTRY Self Emp.	
10a BIRTHPLACE (State or foreign country) West Virginia		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME ?		14 MOTHER'S MAIDEN NAME ?	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1918-1918		16 SOCIAL SECURITY NO 214-01-9874	
17 INFORMANT Mrs Dolly Staniec 611 Longbar Harbor Rd.		Address Harford Co.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Coronary artery occlusion (b) Arteriosclerotic heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 1-11-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Jan. 14, 1967	23c NAME OF CEMETERY OR CREMATORY Mt. View Cem.	23d LOCATION (City or town) (County) (State) Howard Co. Md.
24 FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave. Balto. Md.		25a REC'D BY REGISTRAR JAN 16 1967	25b REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

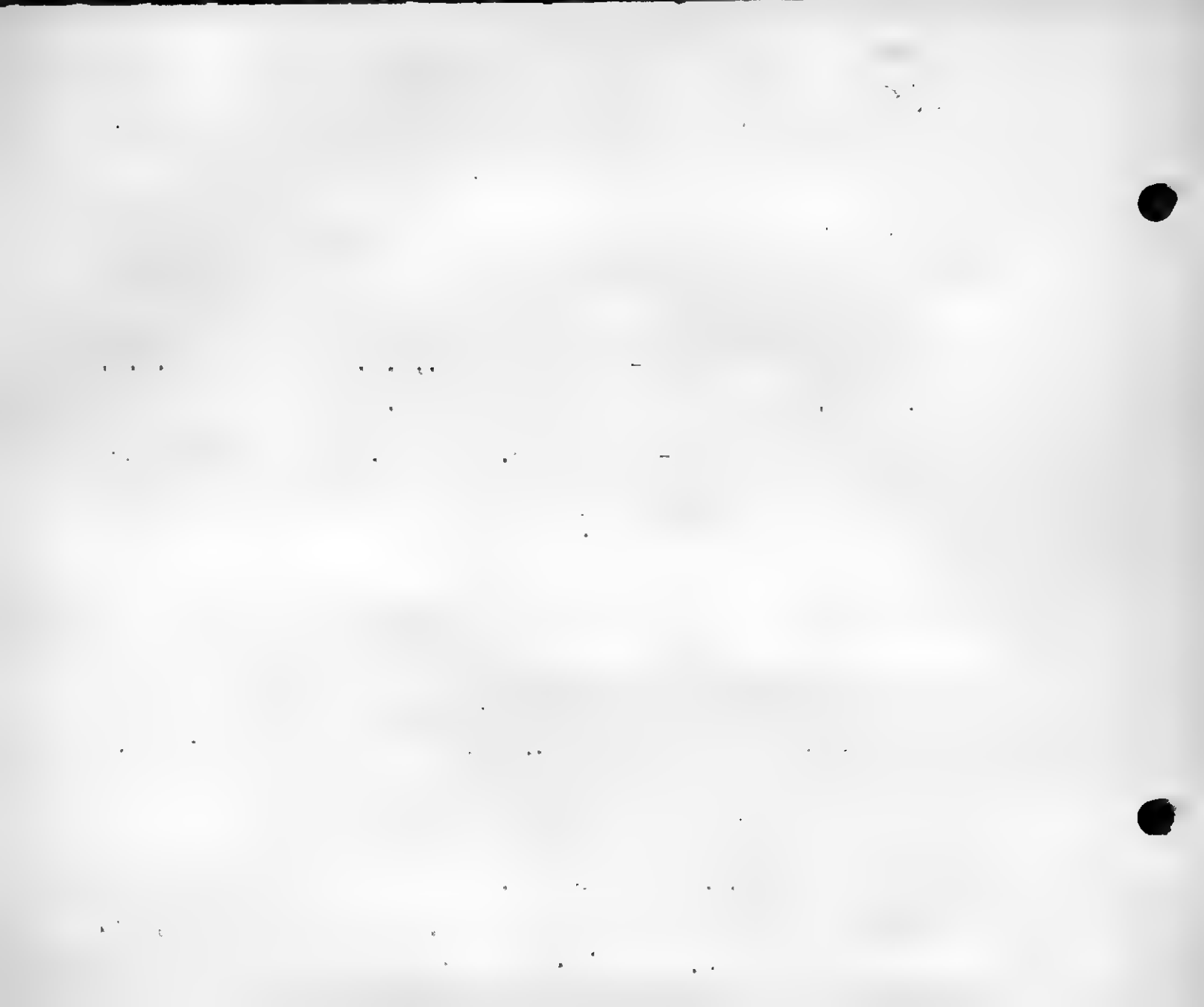
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01188

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01186

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 4100 Fairfax Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Edward Last Hicks		4. DATE OF DEATH Month 1 Day 24 Year 19 67					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 June 1952	9. AGE (In years last birthday) 14 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vernon E. Hicks				14. MOTHER'S MAIDEN NAME Cora L. Walden			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Mr. Vernon E. Hicks (above address) (Father)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain DUE TO Skull fracture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by car.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8:15 p.m. 1-21-1967		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 450, 20 feet west of Woodlawn Dr.		20f. (City or town) Landover, Maryland (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)		22. DATE SIGNED 1-25-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/27/67		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City, town or county) Colmar Manor, Md. (State)	
24. FUNERAL DIRECTOR		ADDRESS Valley Home Inc. Maryland		25a. REC'D BY REGISTRAR DATE 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



01189

CERTIFICATE OF DEATH

01188

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN TB <b>10 hrs. 44mins</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>4818 Eastern Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Boy Hite</b>		4. DATE OF DEATH Month Day Year <b>Jan. 12 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 12, 1967</b>
9. AGE (In years last birthday) yrs <b>10</b>		IF UNDER 1 YEAR Months Days <b>10 44</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Prince George's County</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Guy Russell Hite</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Jean Shipp</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Same as above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>7 2.5</b> IMMEDIATE CAUSE (a) <b>Neonatal Atelectasis</b> DUE TO (b) <b>Premature birth</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 12, 1967</b> , to <b>Jan. 12, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan. 12, 1967</b> , and that death occurred at <b>3:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>L. E. Hoeck</b>		22b. DATE SIGNED <b>Jan-15-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Leroy E. Hoeck, M.D.</b>		22d. ADDRESS <b>3611 Branch Ave. S.E. Wash. D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>1/21/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Prince Georges Gen. Hosp.</b>	23d. LOCATION (City or Town) (County) (State) <b>Cheverly PG Maryland</b>
24. FUNERAL DIRECTOR <b>Harry A. Penn, Jr., Admin., Cheverly, Maryland</b>		25a. REC'D BY REGISTRAR <b>JAN 25 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





01190

## CERTIFICATE OF DEATH

01189

1 PLACE OF DEATH a. COUNTY <b>P. G. County</b> <b>Riverdale</b> <b>Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery County</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale, Md.</b>		c LENGTH OF STAY IN 1b <b>10 Days.</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Hospital,</b>		d. STREET ADDRESS <b>10227 Greenforest Drive,</b>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <b>Nellie Virginia Hoffmaster</b>		4. DATE OF DEATH <b>1-13-67</b>	
5. SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>11-13-07</b>
9. AGE (In years last birthday) <b>59 yrs</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Cleaners,</b>	
12. BIRTHPLACE (County & State, or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Amer</b>	
13. FATHER'S NAME		14 MOTHER'S MAIDEN NAME <b>Emma Rinker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>218-20-0398</b>	
17. INFORMANT <b>Eugene Leland Hospital, 4408-Queensbury Dr.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Brain tumor Rt Temporal lobe</b> DUE TO (b) <b>Symptoms for 3 weeks</b> DUE TO (c) <b>for 3 weeks</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 1966</b> to <b>Jan 13, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan 13, 1967</b> , and that death occurred at <b>4:25 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>L W Malin</b>		22b. DATE SIGNED <b>Jan 13, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>L W Malin M.D.</b>		22d. ADDRESS <b>Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVA. (Specify) <b>burial</b>	23b. DATE THEREOF <b>1/17/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Montgomery County, Md.</b>
24. FUNERAL DIRECTOR <b>The H. Hines Co. Roland G. Hines</b>		25a. REC'D BY REGISTRAR <b>Jan 18 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01191

## CERTIFICATE OF DEATH

01190

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN lb <u>5 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eugene Island Memo</u>		d. STREET ADDRESS <u>4503 Oliver St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Myra</u> Middle <u>M.</u> Last <u>Holmes</u>		4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-27-73</u>
9. AGE (In years last birthday) <u>93</u> yrs		IF UNDER 1 YEAR Months <u>5</u> Days <u>16</u> Hours <u>1</u> Min <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Minn</u>		12. CITIZENSHIP OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Roup</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records Riverdale, Md</u>		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>45010</u> IMMEDIATE CAUSE (a) <u>GEN. ARTERIOSCLEROSIS</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-30</u> , 19 <u>66</u> , to <u>1-5</u> , 1967, that (I) (we) last saw the deceased alive on <u>1-5</u> , 1967, and that death occurred at <u>2:33</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>C.J. Houmann</u>		22b. DATE SIGNED <u>1-5-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C.J. HOUMANN</u>		22d. ADDRESS <u>RIVERDALE MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Jan. 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FT. Detrick Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cabin Mountain S.S. Dist</u>
24. FUNERAL DIRECTOR <u>F. S. Galt</u>		25a. REC'D BY REGISTRAR <u>JAN 10 1967</u>	
ADDRESS <u>3095 Hyattsville, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Judge</u>	



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01192

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01187

1 PLACE OF DEATH a. COUNTY <u>Riverdale</u> P.G. <u>P.G.</u> Md. <u>Md.</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>P.G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY in lb <u>12 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eugene Leland Hospital</u>				d. STREET ADDRESS <u>9098 Balt-Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>S</u> Last <u>Jack</u>				4 DATE OF DEATH Month <u>1-</u> Day <u>20</u> Year <u>67</u>			
5 SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>6-21-00</u>	
9. AGE (In years lost birthday) <u>66</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>Amer.</u>				13 FATHER'S NAME <u>Thomas Henry Hodgkiss</u>			
14 MOTHER'S MAIDEN NAME <u>Jane Wilson Pettigrew.</u>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO				17. INFORMANT <u>Eugene Leland Hospital, 4408 Queensbury Dr.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> 287X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PICKWICKIAN SYNDROME</u> DUE TO (c) <u>UNKNOWN</u>				INTERVAL BETWEEN ONSET AND DEATH <u>ONE DAY</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS</u>				19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> , 19 <u>65</u> , to <u>1-20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-20</u> 19 <u>67</u> , and that death occurred at <u>6:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>C.J. HOUmann</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C.J. HOUmann M.D.</u>				22d. ADDRESS <u>RIVERDALE MD</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JAN 24, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		23d. LOCATION (City or Town) (County) (State) <u>Adelphi, Pr. Geo Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>				25a. REC'D BY REGISTRAR <u>254 Carroll St NW Washington DC</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01193

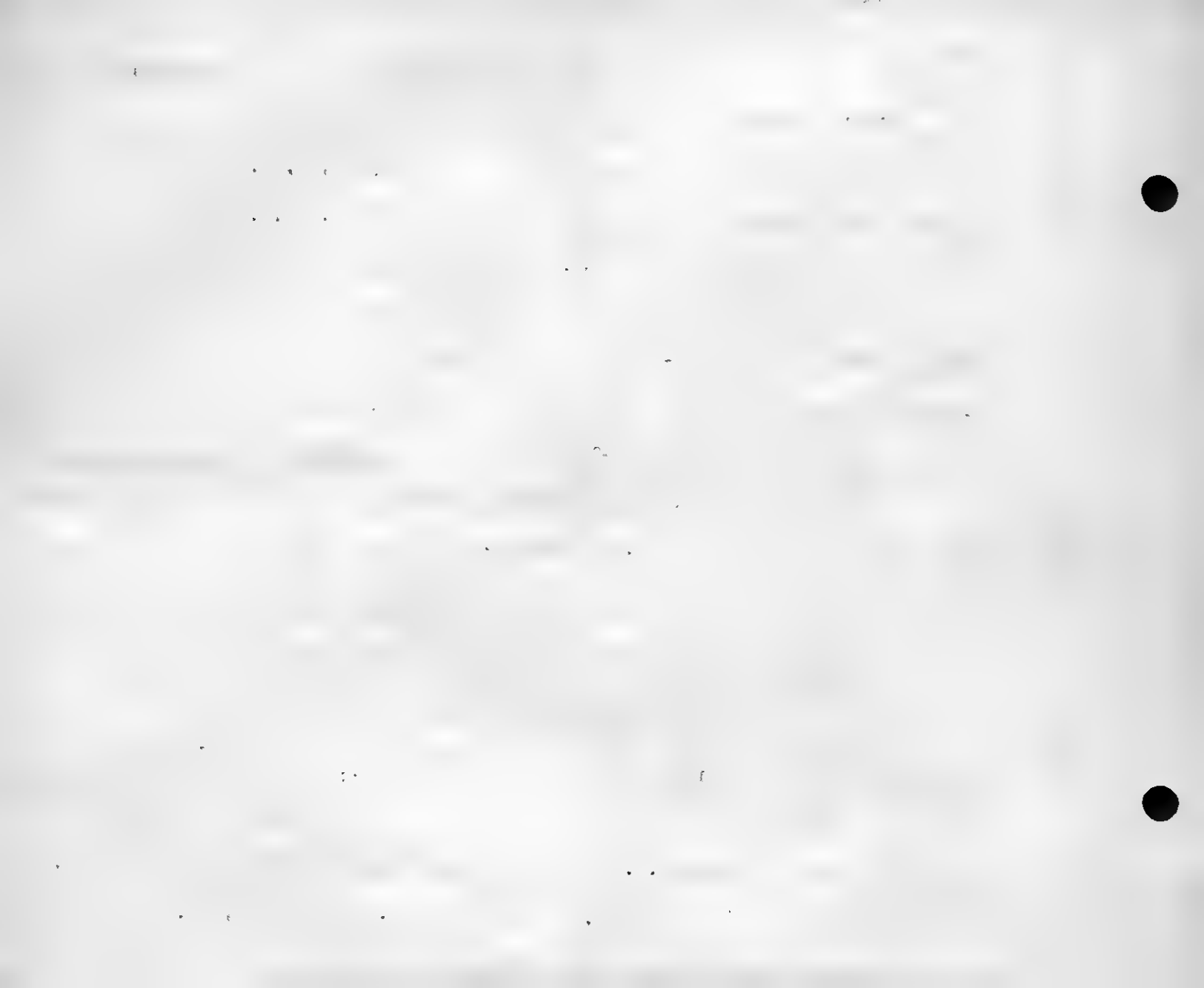
## CERTIFICATE OF DEATH

01191

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>1816 13th St., N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>F. R.</b> Last <b>Jackson</b>		4. DATE OF DEATH Month <b>1</b> Day <b>11</b> Year <b>19 67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/23/1916</b>
9. AGE (In years last birthday) yrs <b>50</b>		10. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
11. CITIZEN OF WHAT COUNTRY? <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clifford Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Navy 1943 - 1946</b>		16. SOCIAL SECURITY NO. <b>577-18-2653</b>	
17. INFORMANT <b>decendent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>massive pulmonary hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>pulmonary tuberculosis, far advanced</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>23 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10/26/1966</b> to <b>1/11/67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1/11/1967</b> , and that death occurred at <b>2:35 P.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>1/11/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22d. ADDRESS <b>Glenn Dale Hospital, Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/18/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>	23d. LOCATION (City or town) (County) (State) <b>Arlington, Va.</b>
24. FUNERAL DIRECTOR <b>Thomas T. Reynolds - 301-124-1776</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 17 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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01194

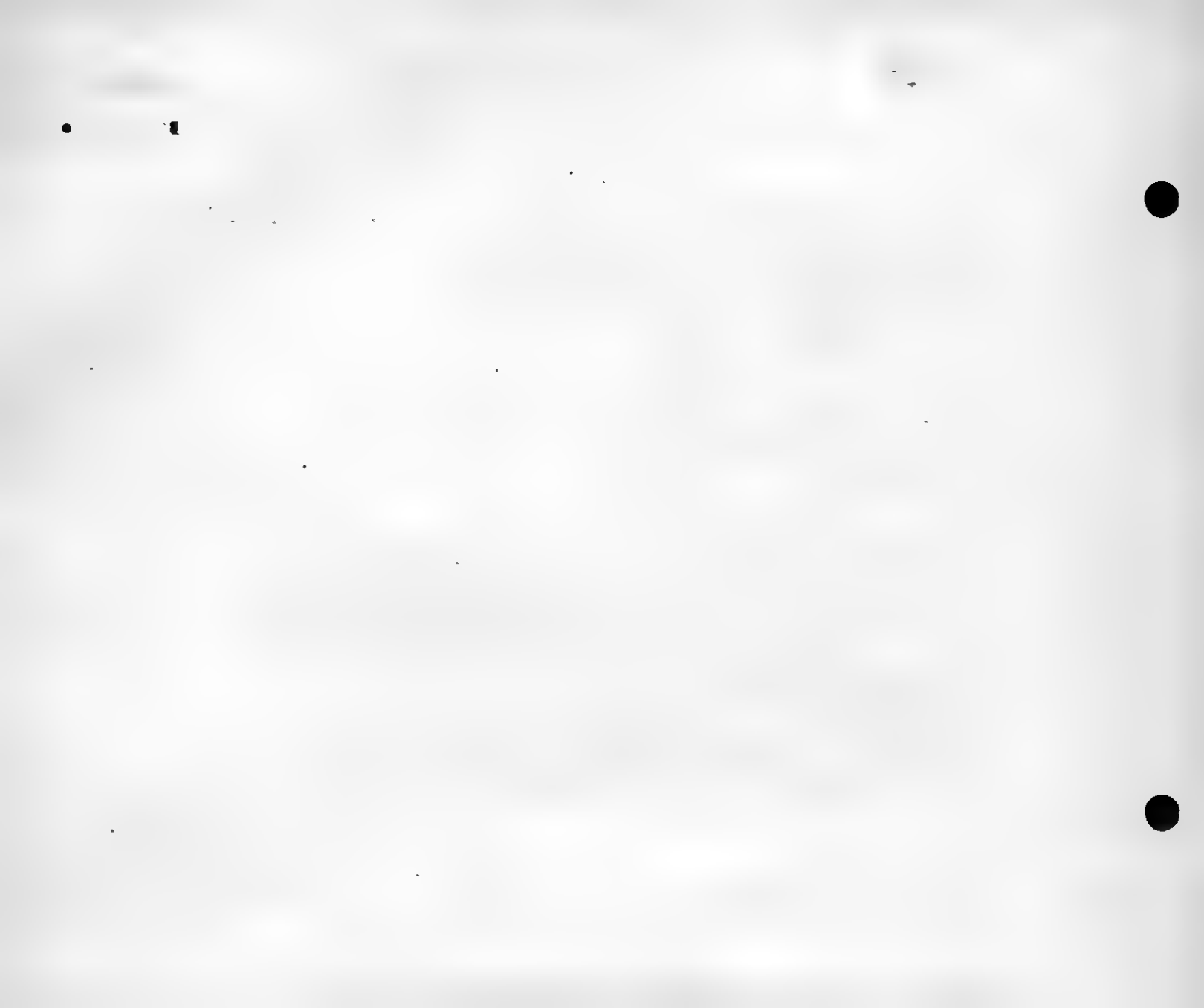
## CERTIFICATE OF DEATH

01192

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>15 hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Memorial</b>		d. STREET ADDRESS <b>2711 Felter Lane (20715)</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Pearl Elizabeth Jackson</b>		4. DATE OF DEATH Month Day Year <b>1 19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/5/08</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Implants Foods Inc.</b>	9 AGE (In years last birthday) yrs <b>58</b>
11 BIRTHPLACE (County & State, or foreign country) <b>Penn.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Laura Krause</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>203-10-8387</b>	
17 INFORMANT <b>Hospital Records.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>163X</b> <b>Stroke of heart with</b> DUE TO <b>myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>myocardial infarction</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>JUN 18, 1967</b> , to <b>JUN 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>JUN 18, 1967</b> , and that death occurred at <b>2A M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>L W Malin</b>		22b. DATE SIGNED <b>1-19-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>L W Malin MD</b>		22d. ADDRESS <b>RIVERDALE, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>1-23-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON VA.</b>
24 FUNERAL DIRECTOR <b>W.W. Chambers Co</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 23 1967</b>	
ADDRESS <b>RIVERDALE, MD</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

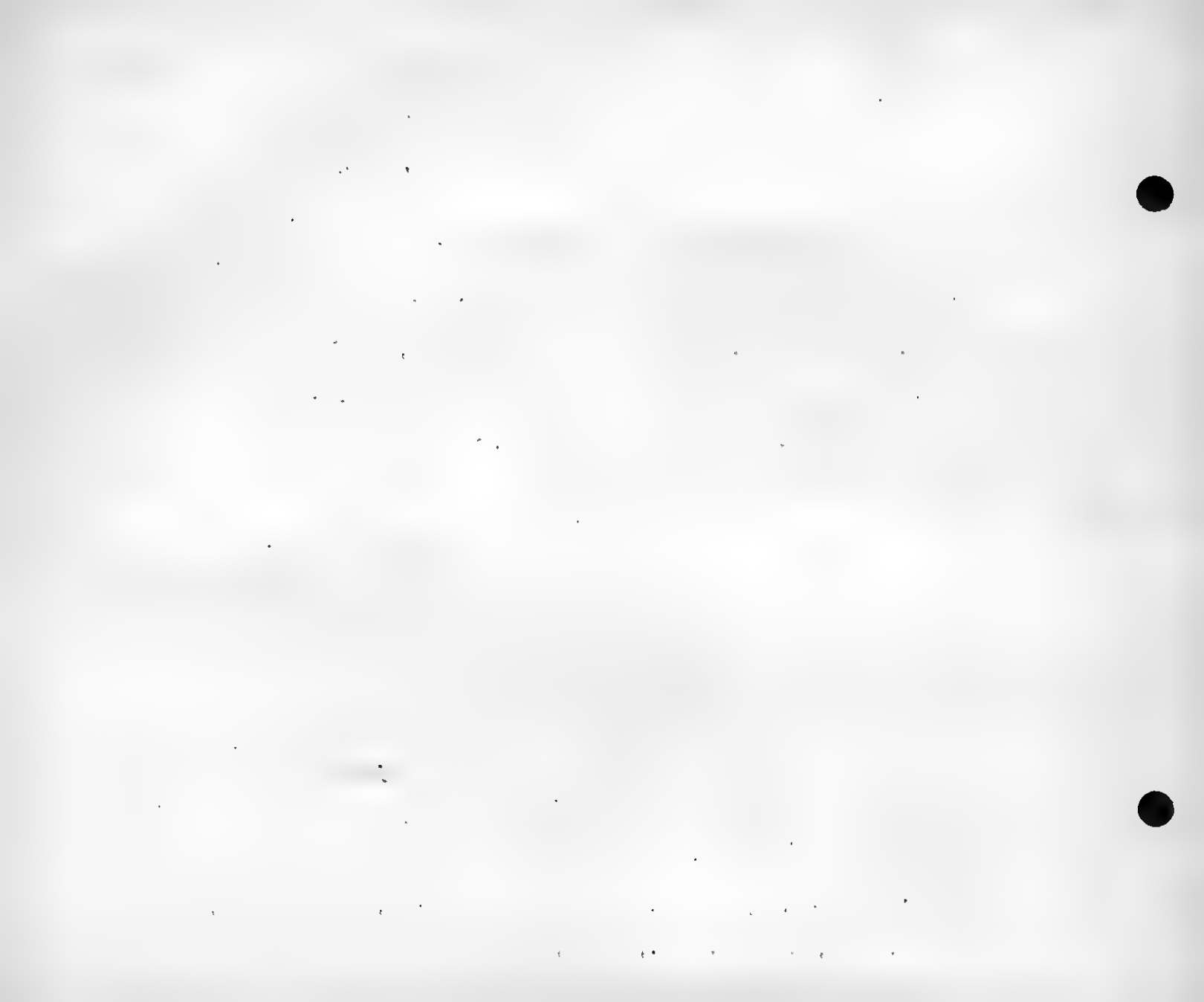
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

01193

01193

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>74</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>6509 Landover Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>George</b> First <b>Richard</b> Middle <b>James</b> Last <b>XXXXXXX</b>		4. DATE OF DEATH <b>Jan. 15 1967</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 15, 1904</b>		9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Simons Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Ret. Simons Co.</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Easton, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Henry Jamesx</b>								14. MOTHER'S MAIDEN NAME <b>Ella R. Stimmel</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>162-03-9199</b>				17. INFORMANT <b>Mrs. Marty James, same as #2</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> DUE TO <b>Arteriosclerotic Heart Disease</b> (b) <b>Myocardial Infarction</b> DUE TO <b>Coronary Atherosclerosis</b> (c) <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <b>10-12 hrs</b> <b>conclusion</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 1966</b> , to <b>1-15, 1967</b> , that (I) (we) last saw the deceased alive on <b>1-15, 1967</b> , and that death occurred at <b>2:45 AM</b> , from the causes and on the date stated above.																			
22a. SIGNATURE <b>Dr. J. L. ...</b>												22b. DATE SIGNED <b>Jan. 15, 1967</b>							
22c. PHYSICIAN'S NAME (Type) <b>5813 Landover Rd</b>												22d. ADDRESS <b>5813 LANDOVER RD, CHEVERLY, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>Jan. 18, 1967</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Abington Hills Cemetery, Clark Summit, Pennsylvania</b>				23d. LOCATION (City, town or county) (State) <b>Clark Summit, Pennsylvania</b>							
24. FUNERAL DIRECTOR <b>Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland</b>												25a. REC'D BY REGISTRAR <b>Jan 25 1967</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01196

CERTIFICATE OF DEATH

01194

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tanham		c. LENGTH OF STAY IN 1b 77 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tanham		d. STREET ADDRESS 175 Sunset Lane	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Tanham		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph Frederick Jensen First Middle Last		4. DATE OF DEATH Month 1-7- Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-16-01
9. AGE (In years lost birthday) yrs 66		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Denmark		12. CITIZEN OF WHAT COUNTRY? Denmark	
13. FATHER'S NAME Nels Jensen		14. MOTHER'S MAIDEN NAME Anna Marie Anderson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown yes		16. SOCIAL SECURITY NO. Admission sheet.	
17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Chronic Glomerular Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> (c) <u>1967</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 1960 to Jan 7, 1967, that (I) (we) last saw the deceased alive on Jan 6, 1967, and that death occurred at M, from causes and on the date stated above.			
22a. SIGNATURE L W Malin		22b. DATE SIGNED Jan 7, 1967	
22c. PHYSICIAN'S NAME (Type) L W Malin MD		22d. ADDRESS Riverdale, Ind.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE THEREOF Jan 9, 1967	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JAN 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Oudea			



01197

## CERTIFICATE OF DEATH

01195

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW CARROLLTON,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magnolia Gardens' Nursing Home</u>		d. STREET ADDRESS <u>6213 WESTBROOK DRIVE</u>	
3. NAME OF DECEASED (Type or print) <u>Annie Wheat Jones</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 Aug. 1894</u> 72 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>GEORGIA</u>
13. FATHER'S NAME <u>HARVEY L. WHEAT</u>		14. MOTHER'S MAIDEN NAME <u>ALA. DOE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MRS DUBLEY SMITH.</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>central thrombosis</u> 3500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>central arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>month</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/6/67</u> , 19 <u>67</u> to <u>4/10/67</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased give an <u>1/10</u> 19 <u>68</u> , and that death occurred at <u>6:21</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Leon Levitski</u>		22b. DATE SIGNED <u>1-10-1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEON LEVITSKI</u>		22d. ADDRESS <u>MT. LAUREL, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>13 JAN 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RIVERSIDE CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>MACON, GEORGIA.</u>
24. FUNERAL DIRECTOR <u>W.H. Chambers Co. Riverdale, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 11 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





01198

## CERTIFICATE OF DEATH

01196

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Maryland Hosp Center</u>		d. STREET ADDRESS <u>9504 MICHAEL DR.</u>	
3. NAME OF DECEASED (Type or print) <u>MARTHA A. JONES</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>25</u> Year <u>1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8/9/91</u>
9. AGE (In years last birthday) <u>75</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>RICHARD T. MULLIKIN</u>		14. MOTHER'S MAIDEN NAME <u>BARBARA MOORE</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO	
17. INFORMANT <u>DOROTHY G. PEEPLES</u>		Address <u>4912 T ST. SE. WASH. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO (b) <u>GENERALIZED CARCINOMATOSIS</u> DUE TO (c) <u>ADENOCARCINOMA OF STOMACH WITH ASCITES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE HEART FAILURE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. TO CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month Day Year <u>None</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>None</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1966</u> to <u>Present</u> that (I) (we) last saw the deceased alive on <u>Jan 25 1967</u> and that death occurred at <u>8:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Arthur Shaver Jr.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR.</u>		22d. ADDRESS <u>8808 BRANCH AVE - CLINTON MD</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/28/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FORESTVILLE METH. CHURCH</u>		23d. LOCATION (City or Town) (County) (State) <u>FORESTVILLE, PG, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>4308 SUITLAND RD.</u> ADDRESS <u>ROBERT E. WILHELM FUNERAL HOME SUITLAND Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 27 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01199

CERTIFICATE OF DEATH

01197

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 1b <b>81 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>W.</b> Last <b>Kearns</b>		4. DATE OF DEATH Month <b>January</b> Day <b>10</b> Year <b>19 67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/18/1898</b>
9. AGE (In years last birthday) yrs <b>68</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Kearns</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Price</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-14-8129</b>	
17. INFORMANT <b>decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>Status post left femoral-popliteal artery</b> (b) <b>by-pass graft</b> DUE TO <b>Generalized arteriosclerosis</b> (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>10 days</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>(*)</del> (this hospital) attended the deceased from <b>10/21/ 1966</b> to <b>1/10/19 67</b> , that <del>(*)</del> (we) last saw the deceased alive on <b>1/10/ 19 67</b> , and that death occurred at <b>5:30AM</b> , from causes and on the date stated above			
22a. SIGNATURE <i>Moe Weiss</i>		22b. DATE SIGNED <b>1/10/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>1-17-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY</b>	23d. LOCATION (City or Town) (County) (State) <b>LANDOVER, MD.</b>
24. FUNERAL DIRECTOR <b>Rollins 4339 Hunt PL. N.E.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 17 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

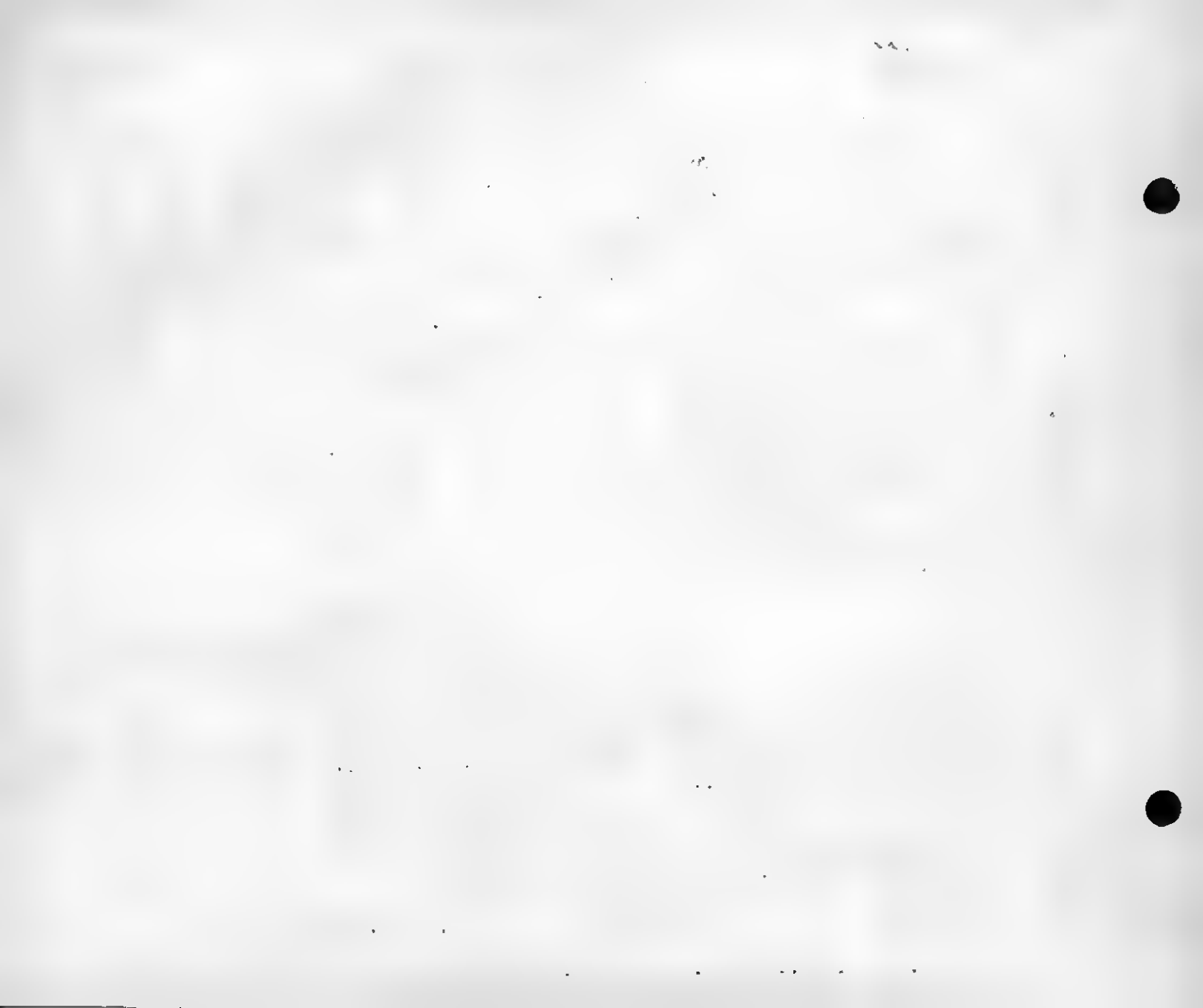
01200

## CERTIFICATE OF DEATH

01198

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> MARYLAND				<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>12 hrs 37mins</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>6922 Decatur Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3 NAME OF DECEASED</b> (Type of print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Kelly</u>				<b>4 DATE OF DEATH</b> Month <u>Jan</u> Day <u>11</u> Year <u>19 67</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10 Jan., 1967</u>	
9 AGE (in years last birthday) yrs <u>12</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u>		IF UNDER 24 HRS Hours <u>12</u> Min <u>37</u>		10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Prince George's County</u>				12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>David Maurice Kelly</u>				14. MOTHER'S MAIDEN NAME <u>Carolyn Fage Foster Kelly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO.		17. INFORMANT <u>Same as above</u>	
<b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Atelictasis Neonatorum</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 10., 1967</u> , to <u>Jan. 11., 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan. 11., 1967</u> , and that death occurred at <u>5:00 A.M.</u> from causes and on the date stated above							
22a. SIGNATURE <u>John H. Moling, III, M.D.</u>				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Moling, III, M.D.</u>				22d. ADDRESS <u>1207 Linden Lane, Bowie, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>1/21/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Gen. Hosp. Cheverly PG Maryland</u>		23d. LOCATION (City or Town) (County) (State)	
24 FUNERAL DIRECTOR <u>Harold W. Penny Jr., Admin., Cheverly, Maryland</u>				25a. REC'D BY REGISTRAR <u>JAN 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.



01201

## CERTIFICATE OF DEATH

01199

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN TB <b>38 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>3311 Bellevue Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Curt R. Keusch</b>		4. DATE OF DEATH Month Day Year <b>January 14 19 67</b>	
5. SEX <b>Male</b>	6. CO. OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/23/1902</b>
9. AGE (In years last birthday) <b>64</b> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U S Government</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Herman Keusch</b>		14. MOTHER'S MAIDEN NAME <b>Anna M Woite</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>579 40 3536</b>	
17. INFORMANT <b>Anne E Keusch</b>		Address <b>Cheverly, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Cardiac Failure</b> DUE TO <b>Carcinoma Left Lung</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>5 weeks</b> <b>15 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct</b> , 1965, to <b>Jan</b> , 1967, that (I) (we) lost saw the deceased alive on <b>1-13</b> , 1967, and that death occurred at <b>6:15</b> P.M. from causes and on the date stated above.			
22a. SIGNATURE <b>Thomas M. Hutchins</b>		22b. DATE SIGNED <b>1-14-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas M. Hutchins</b>		22d. ADDRESS <b>7315 Landoner Rd. Hyattsville, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan 17, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington D. C.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons - Hyattville, Md</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 16 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





01202

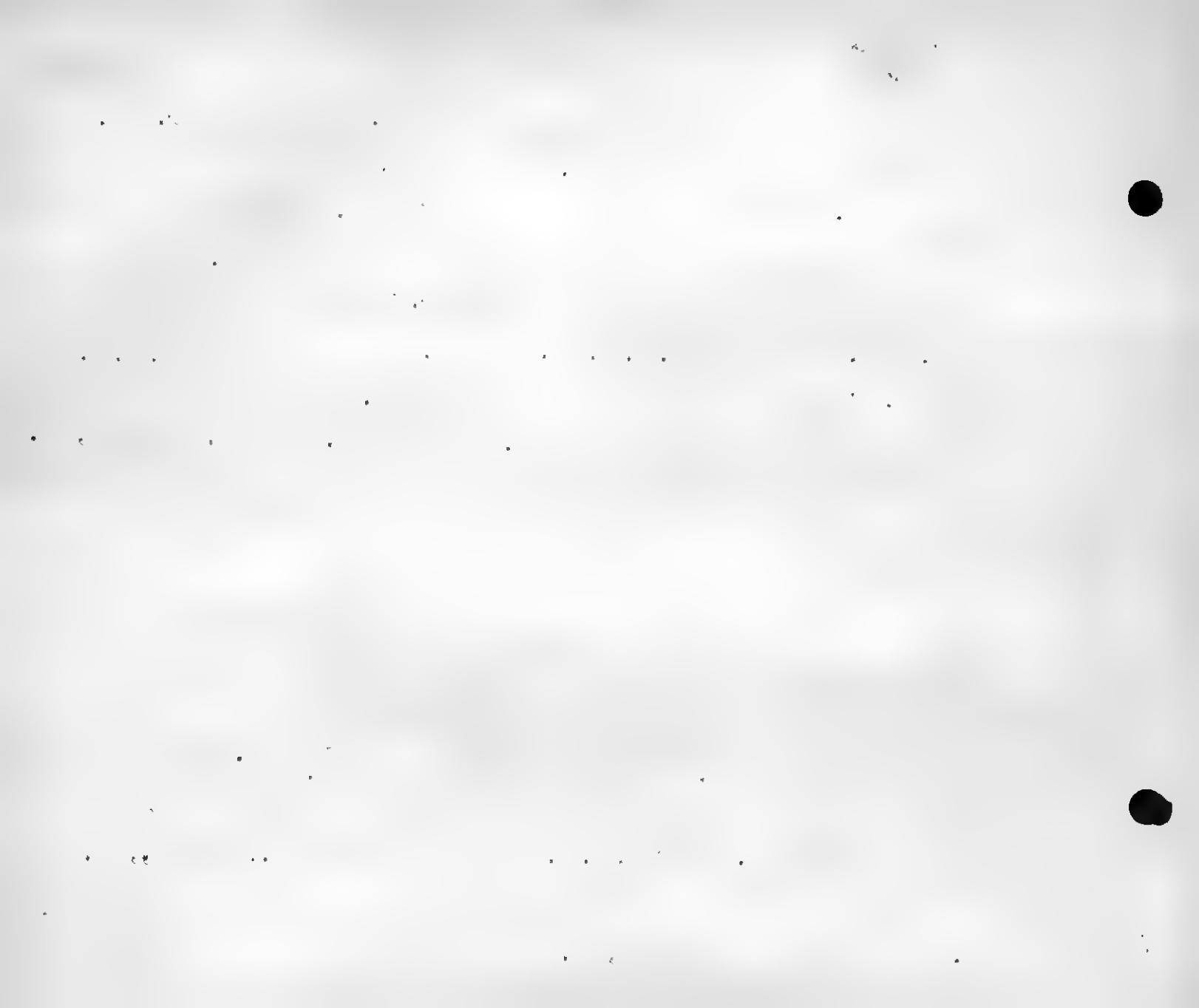
## CERTIFICATE OF DEATH

01200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood		c. LENGTH OF STAY IN 1b 40 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4403 38th. Street		e. STREET ADDRESS 4403 38th. Street	
3 NAME OF DECEASED (Type or print) GEORGE First HARDY Middle KIDWELL Last		4 DATE OF DEATH Jan. 22 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 Mar. 1888
9 AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Engr.		10b. KIND OF BUSINESS OR INDUSTRY Pa. R. R. Co.	
11. BIRTHPLACE (County & State, or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John F. Kidwell		14. MOTHER'S MAIDEN NAME Susan B. Campbell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) No None		16. SOCIAL SECURITY NO.	
17. INFORMANT R. Ashby Kidwell. Brother.		Address: Brentwood, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO (b) Coronary Insufficiency DUE TO (c) Arterio-sclerosis			INTERVAL BETWEEN ONSET AND DEATH 24 hours 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour "o.m." p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 15, 1951, to Jan. 22, 1967, that (I) (we) last saw the deceased alive on Jan. 21, 1967, and that death occurred at 4: P.M. from causes and on the date stated above			
22a. SIGNATURE Thomas M. Hutchins		22b. DATE SIGNED 1/22/67	
22c. PHYSICIAN'S NAME (Type) Thomas M. Hutchins, M. D.		22d. ADDRESS 7315 Landover Rd., Kentvil., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan 26, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	



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VR A15 (4)  
20 M 1/66

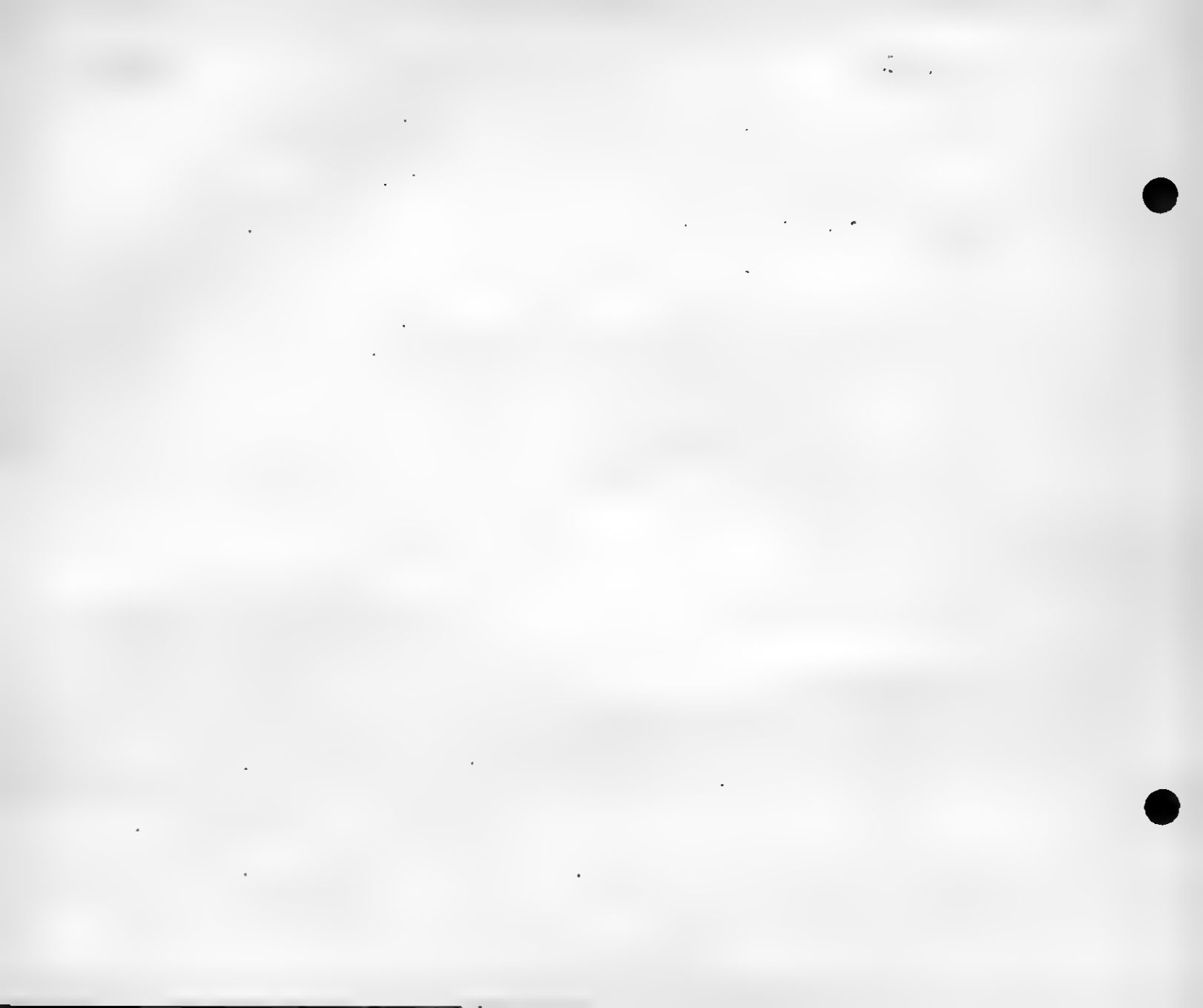
01203

CERTIFICATE OF DEATH

01201

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>16 days</b>			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Youngstown</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>2014 Logan Ave.</b>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary E Langham</b>			4. DATE OF DEATH Month Day Year <b>Jan 10 19 67</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>23 Nov., 1897</b>		9. AGE (In years last birthday) <b>69</b> Yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H/W</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Joseph Dudley</b>		
14. MOTHER'S MAIDEN NAME <b>Louisa Robinson</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO <b>292 09 0841</b>		17. INFORMANT <b>Franklin W Langham</b> Address <b>Youngstown Ohio</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Disease</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Recent Cerebrovascular Accident</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 25, 1966</b> , to <b>Jan. 10, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan. 10, 1967</b> , and that death occurred at <b>7:50 PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Edwin J. Jensen</b>			22b. DATE SIGNED <b>Jan. 11, 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>			22d. ADDRESS <b>Prince George's Gen. Hospital</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan 14, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Tod Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Youngstown Ohio</b>		
24. FUNERAL DIRECTOR <b>. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>JAN 16 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

MEDICAL CERTIFICATION

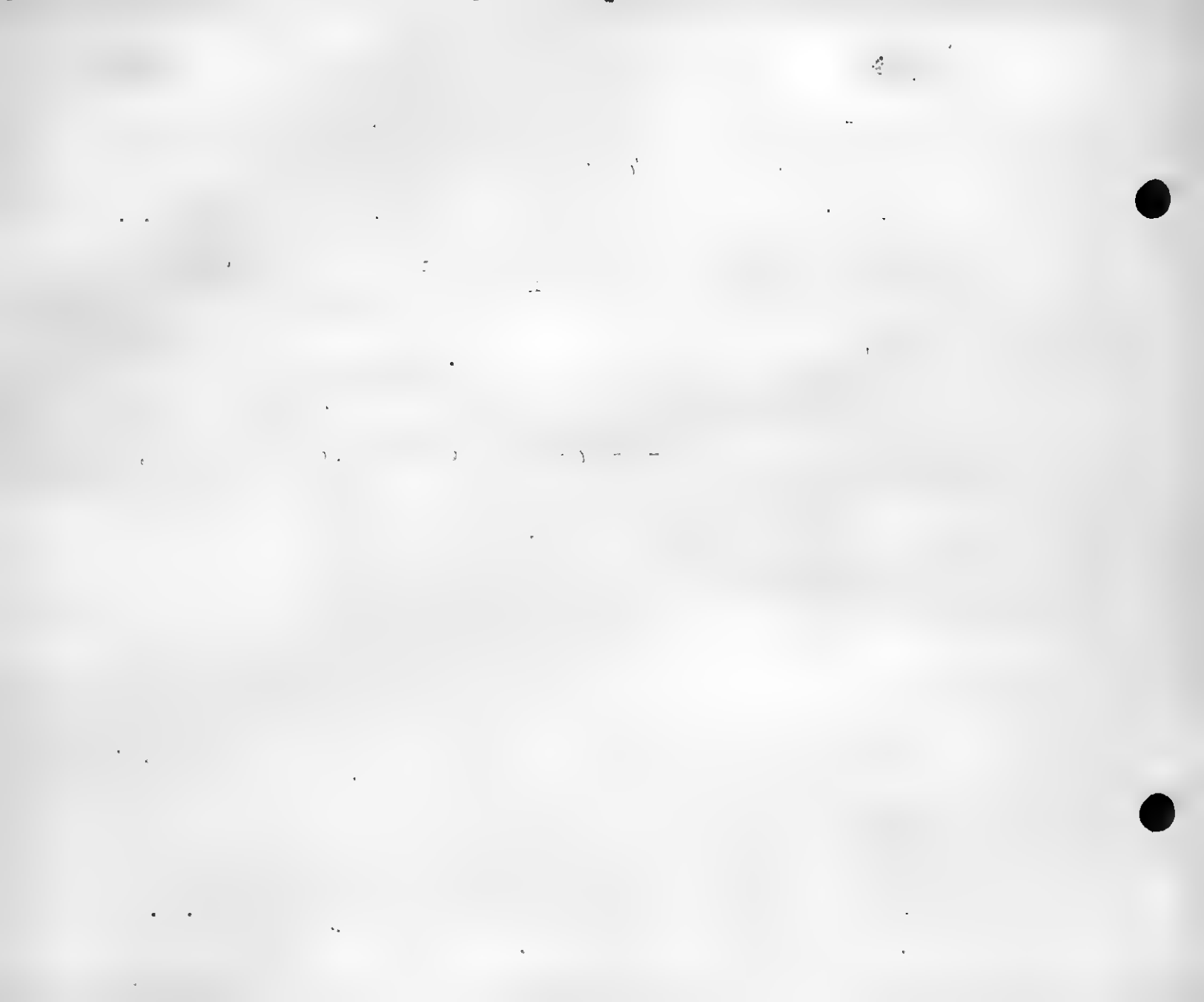


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VR A15 (4)  
20M 1/65

7 Maryland State Department of Health											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01204						01202					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <b>Prince George</b>						a. STATE <b>District of Columbia</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>						b. COUNTY <b>District of Columbia</b>					
c. LENGTH OF STAY IN IS <b>7 years</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Home</b>						d. STREET ADDRESS <b>1822 Irving Street, N.W.</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
<b>Delia</b>			<b>Bridgett</b>			<b>Lanigan</b>			<b>January 24 19 67</b>		
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 20, 1872</b>		9. AGE (In years last birthday) <b>94</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infants' Nurse</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Co. Tipperary, Ireland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Richard Lanigan</b>						14. MOTHER'S MAIDEN NAME <b>Mary Slattery</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>220-54-0978-T</b>		17. INFORMANT <b>Sacred Heart Home, Hyattsville, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> DUE TO (b) <b>Arrhythmia Fibrillation</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1-17</b> , 19 <b>67</b> to <b>1-24</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>1-17</b> , 19 <b>67</b> , and that death occurred at <b>10:45</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>August W. M. Laurin</b>								22b. DATE SIGNED <b>Jan. 25, 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>F. Gasch's Sons</b>						22d. ADDRESS <b>Hyattsville, Md.</b>		22e. REC'D BY REGISTRAR <b>JAN 30 1967</b>		22f. REGISTRAR'S SIGNATURE <b>W. M. Laurin</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Jan 28, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Washington D. C.</b>		



01205

CERTIFICATE OF DEATH

01203

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>5 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park=</b>		d. STREET ADDRESS <b>4812 College Rv</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John T Lappin</b>		4. DATE OF DEATH Month Day Year <b>Jan 25 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SEPT DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 Nov., 1913</b>
9. AGE (n years last birthday) <b>53 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electric Lighting</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John A Lappin</b>		14. MOTHER'S MAIDEN NAME <b>Mary Mash</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO <b>11</b>	
17. INFORMANT <b>Lillian B Lappin</b>		Address <b>College Park, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia</b> DUE TO (b) <b>Cirrhosis of liver</b> DUE TO (c) <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4 days</b> <b>1 year</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bleeding from Stomach</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1-25-1967</b> to <b>1-25-1967</b> , and that death occurred on <b>3:00 AM</b> from causes and on the date stated above			
22a. SIGNATURE <b>Dayton Watkins</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>DAYTON WATKINS</b>		22d. ADDRESS <b>5318 Annapolis Rd Baltimore, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan 27, 1967</b>	23c. NAME OF CEMETERY OR CREMATOR <b>Arlington National</b>	23d. LOCATION (City or town) (County) (State) <b>Arlington Virginia.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>Jan 30 1967</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

01206

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01204

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY Prince George's		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN TB DOA		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital			d STREET ADDRESS 107 4th Avenue		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Yoneko Middle M Last Levin			4 DATE OF DEATH Month January Day 27 Year 19 67		
5 SEX Female	6 COLOR OR RACE oriental	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 4, 1932	9 AGE (In years last birthday) 34 yrs	FUNERAL 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY AT HOME		11 BIRTHPLACE (State or foreign country) OKINAWA, RYUKYU ISLANDS U.S. OCCUPIED	
13 FATHER'S NAME KINJI KINJO			14 MOTHER'S M A D E N NAME UNKNOWN		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO UNKNOWN		17 INFORMANT JAMES T. LEVAN Address SAME AS #2	
18 CAUSE OF DEATH (Enter on y one cause per line for 5) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Undetermined 795.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) Riverdale, Md.		22. DATE SIGNED 1-27-67	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF JAN 31, 1967	23c NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	23d LOCATION (City or Town) (County) (State) ARLINGTON VIRGINIA		
24. FUNERAL DIRECTOR W. W. Chambers Co. Riverdale, Md.		25a REC'D BY REGISTRAR DATE 6 1967	25b REGISTRAR'S SIGNATURE Charles J. J...		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
M  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01207

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01205

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BOWIE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-UPPER MARLBORO				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOWIE					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) JUNCTION OF CROOM STATION ROAD AND CROOMS ROAD, UPPER MARLBORO				d. STREET ADDRESS 3432 MEMPHIS LANE					
3. NAME OF DECEASED (Type or print) First SAYLOR Middle LEROY Last LEVITZ				4. DATE OF DEATH Month JANUARY Day 8 Year 19 67					
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 JAN 35			
9. AGE (In years last birthday) 31 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) LANCASTER, PA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME SAM (NMN) LEVITZ				14. MOTHER'S MAIDEN NAME KATHYRN (NMN) MOYER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. 1956-1959 527-36-6522		17. INFORMANT OFFICIAL U.S. NAVY RECORDS Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INJURIES MULTIPLE EXTREME 500X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AIRCRAFT ACCIDENT					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1107 8 JAN 1967				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) FARM			
20f. (City or town) NEAR UPPER MARLBORO, MD				20g. (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE JOHN KEHOE, MD				22. DATE SIGNED 9 JAN 1967					
EXAMINER'S NAME (Type)				Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1/12/67		23c. NAME OF CEMETERY OR CREMATORY HARRINGTON NAT'L		23d. LOCATION (City, town or county) (State) HARRINGTON, VA.			
24. FUNERAL DIRECTOR W.D. Chambers Co. Inc.				25a. REC'D BY REGISTRAR DATE JAN 13 1967					
25b. REGISTRAR'S SIGNATURE Charles Judge									



FOR STATE  
HEALTH DEPT.

01208

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01206

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 7538 Walters Lane	
3. NAME OF DECEASED (Type or print) First Violet Middle H Last Lewis		4. DATE OF DEATH Month 1 Day 5 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-14-1892
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur Derrick		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT William K. Lewis		Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. pm 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 1-6-67	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF Jan. 9, 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington National
23d. LOCATION (City or Town) (County) (State) Arlington, Virginia		24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Road, Suitland, Md.	
25a. REC'D BY REGISTRAR DATE JAN 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01209

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01207

1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c LENGTH OF STAY IN 1b <u>DOA</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>				d STREET ADDRESS <u>6210 Kingston Road</u>			
3. NAME OF DECEASED (Type or print) <u>Raymond</u> First <u>Francis</u> Middle <u>Luckett</u> Last				4. DATE OF DEATH <u>1</u> Month <u>12</u> Day <u>19</u> Year <u>67</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>3 March 1913</u>	
9 AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>				10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13 FATHER'S NAME <u>John Luckett</u>				14 MOTHER'S MAIDEN NAME <u>Ida May Watson</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>571-40-5615</u>				17 INFORMANT <u>Ruth S. Luckett</u> Address <u>Same as #2</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>over 4 yrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe, M.D.</u>				22. DATE SIGNED <u>1-13-67</u>			
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>				Address (Street, city, town or county)			
23a BURIAL, CREMATION, REMOVAL, OR OTHER		23b DATE THEREOF <u>1/16/1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>Adams Hill</u>		23d LOCATION (City or town) (County) (State) <u>Switzland, Md.</u>	
24 FUNERAL DIRECTOR <u>John A. Mattingly</u>				25a RECD BY REGISTRAR <u>131 J. J. EX-10</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01210

01208

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL-UPPER MARLBORO		c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA		b. COUNTY ALEXANDRIA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) JUNCTION OF CROOM STATION ROAD AND CROOMS ROAD, UPPER MARLBORO						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES WILLIAM		First		Middle		Last LURCOTT		4. DATE OF DEATH Month JANUARY	
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 FEB 1928		9. AGE (in years last birthday) 39 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY		11. BIRTHPLACE (State or foreign country) PHILADELPHIA, PENNSYLVANIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALFRED (NMN) LURCOTT						14. MOTHER'S MAIDEN NAME ESTHER (NMN) THOMAS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 51-60-61-62		17. INFORMANT OFFICIAL U.S. NAVY RECORDS		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INJURIES MULTIPLE EXTREME 860X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) AIRCRAFT ACCIDENT					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1107 305X 8 Jan 1967				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) FARM		20f. (City or town) (County) (State) NEAR UPPER MARLBORO, MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE JOHN KEHOE, MD				22. DATE SIGNED 9 JAN 1967					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 1-12-67		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL CEM FT MYER		23d. LOCATION (City, town or county) (State) VA	
24. FUNERAL DIRECTOR W.W. Chambers Co				ADDRESS 1400 State St NW Wash D.C.		25a. REC'D BY REGISTRAR DATE JAN 13 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

01211

01209

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admn.sion) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY IN 1b 24 Days		d. STREET ADDRESS 2510 Marlboro Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ethel M Madden		4. DATE OF DEATH Month Day Year Jan 15 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 Jan., 1881
9. AGE (In years lost birthday) 85 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CIT ZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Wilson Kirkland		14. MOTHER'S MAIDEN NAME Caroline Fuller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. --	
17. INFORMANT Rosemary C Graham		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Occlusion left coronary artery DUE TO Embolization (b) DUE TO Subacute bacterial endocarditis (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis heart disease			
19. WAS A TOLPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 22, 1966, to Jan 15, 1967 that (I) (we) last saw the deceased alive on Jan 14, 1967, and that death occurred at 8:00 A.M. from causes and on the date stated above.			
22a. SIGNATURE Don B. Cameron		22b. DATE SIGNED Jan 15, 1967	
22c. PHYSICIAN'S NAME (Type) DON B. CAMERON		22d. ADDRESS 3503 PERRY ST. BALTIMORE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan 18, 1967	23c. NAME OF CEMETERY OR CREMATORY Fairlawn Cemetery	23d. LOCATION (City or Town) (County) (State) Decatur, Illinois
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR DATE JAN 17 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01212

01210

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. LENGTH OF STAY in lb <u>to 1/2 DAY</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Laurel General Hospital</u>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
3. NAME OF DECEASED (Type or print) First <u>Julius</u> Middle <u>Bernard</u> Last <u>Marlow</u>		d. STREET ADDRESS <u>2601 Briggs-Chaney Road</u>	
5. SEX <u>Male</u>		6. DATE OF DEATH <u>January 6 1967</u>	
16. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Feb. 25, 1884</u>	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) <u>82</u> yrs. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Dairy Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Montgomery Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>E. Pinkney Marlow</u>		14. MOTHER'S MAIDEN NAME <u>Emma Clark</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Mrs. Katharine McEney</u>		400 Northwest Dr. Silver Spring, Md.	
18. CAUSE OF DEATH (Enter on only one cause; line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>Congestive Heart Failure</u> DUE TO <u>Arteriosclerotic C. V. Disease</u> cause last. <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 mo.</u> <u>10 yr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>1/6/67</u> Hour a.m. <u>19</u> p.m. <u>430 PM</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/12/66</u> to <u>1/6/67</u> that (I) (we) last saw the deceased alive on <u>1/6/67</u> and that death occurred at <u>430 PM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>J. M. Warren</u> M.D. ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. DATE SIGNED <u>1-6-67</u>		22c. PHYSICIAN NAME (Type) <u>J. M. Warren</u>	
22d. ADDRESS <u>Laurel Md</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE THEREOF <u>Jan. 9, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nealsville Presbyterian Cem.</u>	
23d. LOCATION (City, town or county) (State) <u>Nealsville, Maryland</u>		23e. REC'D BY REGISTRAR <u>JAN 11 1967</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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*[Faint, illegible handwritten text.]*



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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01213

## CERTIFICATE OF DEATH

01211

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Md		c. LENGTH OF STAY IN b. Yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 504 9th St.		e. STREET ADDRESS 504 9th Street.	
3. NAME OF DECEASED (Type or print) First Middle Last RUSSELL MATTHEWS		4. DATE OF DEATH Month Day Year Jan. 14, 1967	
5. SEX Male	6. CO. OR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1912
9. AGE (In years last birthday) 54 yrs		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paint Worker		11b. KIND OF BUSINESS OR INDUSTRY Store	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Matthews		14. MOTHER'S MAIDEN NAME Pearl Mitchell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Sarah Matthews (same as above)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4110A DUE TO Acute Myocardial Infarction (b) Chronic Mitral insufficiency and chronic congestive Heart Failure (c) DUE TO			
19. INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1956, 19 Jan. 14, 1967 that (I) (we) last saw the deceased alive on Jan. 14, 1967, and that death occurred at 12:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Robert C. Wingfield, M.D.		22b. DATE SIGNED Jan. 16, 1967	
22c. PHYSICIAN'S NAME (Type) Robert C. Wingfield, M.D.		22d. ADDRESS 329 Prince George Street Laurel, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/18/67	23c. NAME OF CEMETERY OR CREMATORY Carver Memorial	23d. LOCATION (City or Town) (County) (State) Laurel, Md
24. FUNERAL DIRECTOR Robert L. Snowden		25a. REC'D BY REGISTRAR DATE JAN 23 1967	
ADDRESS Rockville, Md		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and any event, within 72 hours after death.





01214

## CERTIFICATE OF DEATH

01212

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If the deceased remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>D. C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>708 7th Street S. E.</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>James M. McClanahan</b>		4 DATE OF DEATH Month Day Year <b>January 13 1967</b>	
5. SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <b>Separated</b>	8 DATE OF BIRTH <b>7/7/1888</b>
9. AGE (In years lost birthday) <b>78</b> yrs		IF UNDER 1 YEAR Months Days Hours Min. <b>13</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Leesburg, Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>James W. McClanahan</b>		14. MOTHER'S MAIDEN NAME <b>Mildred Thayer</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>577-28-9352</b>	
17 INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Friedlander's pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebrovascular accident with right hemiplegia</b> DUE TO (c) <b>18 mos.</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary emphysema; hiatal hernia.</b>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>54 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>4</b> (this hospital) attended the deceased from <b>8/27</b> <b>11:45 AM</b> <b>1/13</b> , 1967, that <b>(*)</b> (we) last saw the deceased alive on <b>1/13</b> 19 <b>67</b> , and that death occurred at <b>11:45 AM</b> on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>1/13/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>1/31/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>AMERICAN BOARD</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>
24. FUNERAL DIRECTOR <b>Carl F. Aufrecht</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01213					CERTIFICATE OF DEATH					01213				
1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Chesley - Md.</i> c. LENGTH OF STAY IN 1b <i>6-16-67</i> <i>1-17-67</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Point Branch Nursing Home</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Prince George</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Chesley - Md.</i> d. STREET ADDRESS <i>3127 Parkway</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <i>Michael Blanche Ethel M. Cready</i>					4. DATE OF DEATH Month <i>1</i> Day <i>17</i> Year <i>1967</i>									
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>August 18, 1883</i>		9. AGE (In years last birthday) <i>83</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife Ret.</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Penn.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Samuel Treese</i>					14. MOTHER'S MAIDEN NAME <i>Sarah Kopfort</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give year or dates of service) <i>None</i>					16. SOCIAL SECURITY NO. <i>174-16-9726</i>		17. INFORMANT <i>Mary Wallace</i> Address <i>13015 Tamarack</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary embolism</i> 450 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerosis</i> DUE TO (c) <i>Partial intestinal obstruction</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus</i>									INTERVAL BETWEEN ONSET AND DEATH <i>8 hr.</i> <i>10 yrs.</i> <i>6 mo.</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>8-28</i> , 19 <i>64</i> , to <i>1-17</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>1-16</i> , 19 <i>67</i> , and that death occurred at <i>4:45 PM</i> from the causes and on the date stated above.														
22a. SIGNATURE <i>R D Bauer MD</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <i>1-17-67</i>						
22c. PHYSICIAN'S NAME (Type) <i>R D Bauer MD</i>					22d. ADDRESS <i>2513 Bucklodge Rd. Adelphi Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan 20, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Bladensburg, Maryland</i>							
24. FUNERAL DIRECTOR <i>W W Chambers Co. Riverdale, Md</i>					25a. REC'D BY REGISTRAR <i>DATE JAN 20 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Michael Judge</i>							



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film #G384 1/16/67 pc

01216

CERTIFICATE OF DEATH

01214

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George's County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Prince George's</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b>		c. LENGTH OF STAY IN 1b <b>3hrs-55 mins.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e STREET ADDRESS <b>4319 - 57th Ave.</b>	
3 NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>L.</b> Last <b>McGraw</b>		4 DATE OF DEATH Month <b>Jan</b> Day <b>6</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>Feb 12, 1911</b>
9 AGE (In years, last birthday) <b>55 yrs</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b>19</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRY</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Wm. H. McGraw</b>		14 MOTHER'S MAIDEN NAME <b>Addie Shannon</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 8-5-1945</b>		16. SOCIAL SECURITY NO	
17 INFORMANT <b>Mr. Wm. L. McGraw - Ave., Landover, Md.</b>		Address <b>3221 - 75th</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral infarction &amp; thrombosis</b>		19 WAS ALTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 16, 1966</b> to <b>1-6, 1967</b> , that (I) (we) last saw the deceased alive on <b>1-6, 1967</b> and that death occurred at <b>4:00 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>George H. Hager</b>		22b. DATE SIGNED <b>1-6-67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>3717 - 38th St. Landover, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/10/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>		23d. LOCATION (City or town) (County) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR <b>JAN 12 1967</b>	
ADDRESS <b>Mt. Rainier Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

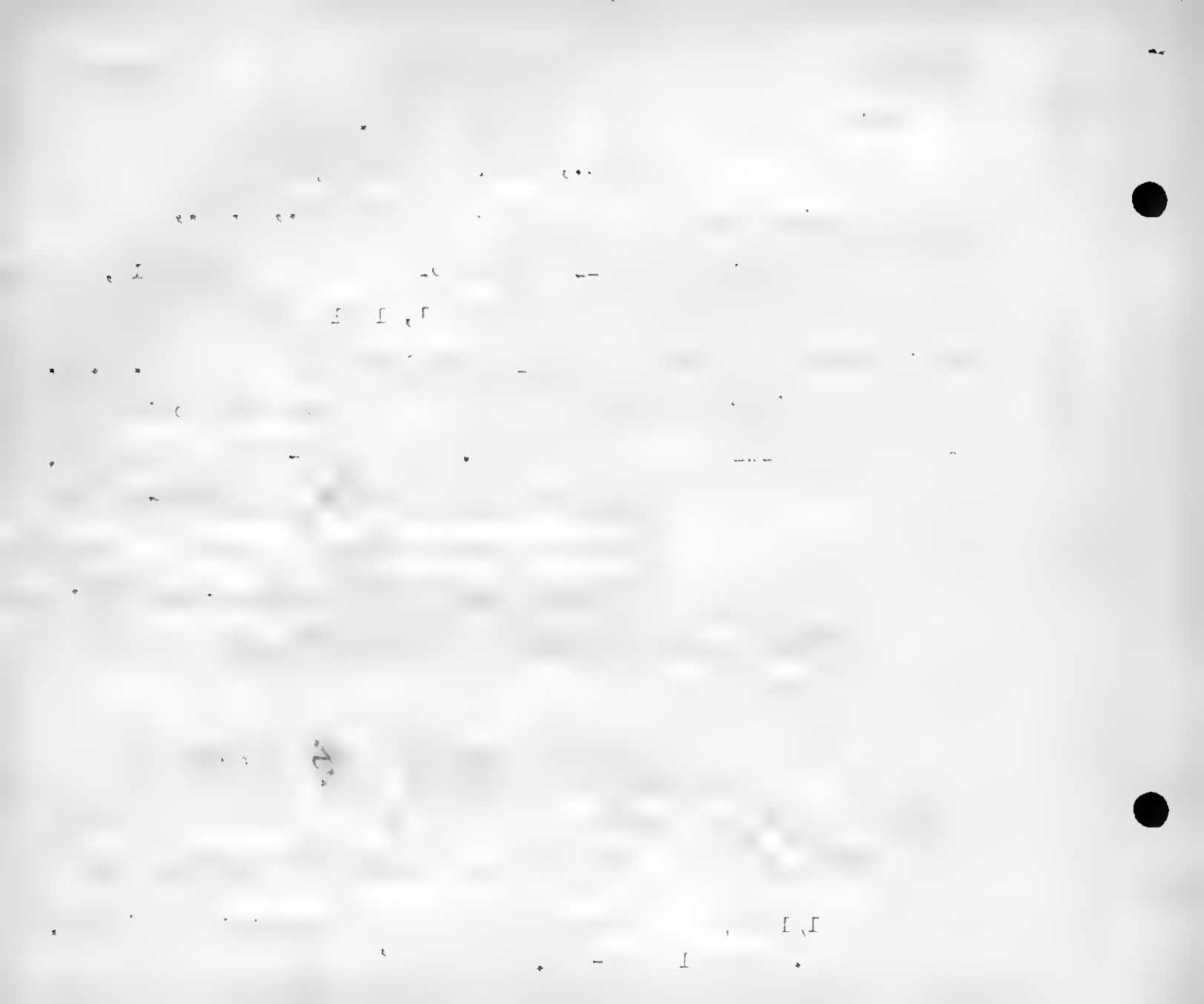
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01217

CERTIFICATE OF DEATH

01215

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>		c. LENGTH OF STAY IN 1b <b>3 Mos., 5 Days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Dist. of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Regent Nursing Home</b>		d. STREET ADDRESS <b>7310 Insoy St., S. E.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth -- McGregor</b>		4. DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21, 1871</b>	9. AGE (In years last birthday) <b>95 yrs.</b>	IF UNDER 1 YEAR Months <b>19</b> Days <b>6</b> Hours <b>7</b> Mm. <b>19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Roderick Mortimer McGregor</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Elizabeth Bowie</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>-----</b>		17. INFORMANT Address <b>Mrs. Grace Wood- Same as Item #2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Acute Circulatory Collapse</b> DUE TO (b) <b>Pneumonitis</b> DUE TO (c) <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary TB</b> INACTIVE INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b> <b>24 hrs</b> <b>5 yrs</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>10/11/67</b> to <b>1/16/67</b> , that (I) (we) last saw the deceased alive on <b>1/16/67</b> , and that death occurred at <b>11:15</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>Kelvin L. Minchin</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/16/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>KELVIN L. MINCHIN</b>		22d. ADDRESS <b>6400 MARLBORO PIKE SE</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/19/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Forestville Md.</b>					
24. FUNERAL DIRECTOR <b>Ritchie Bros. Funeral Home-</b>		ADDRESS <b>Upper Marlboro, Md. 20870</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	
DATE <b>JAN 30 1967</b>					





01218

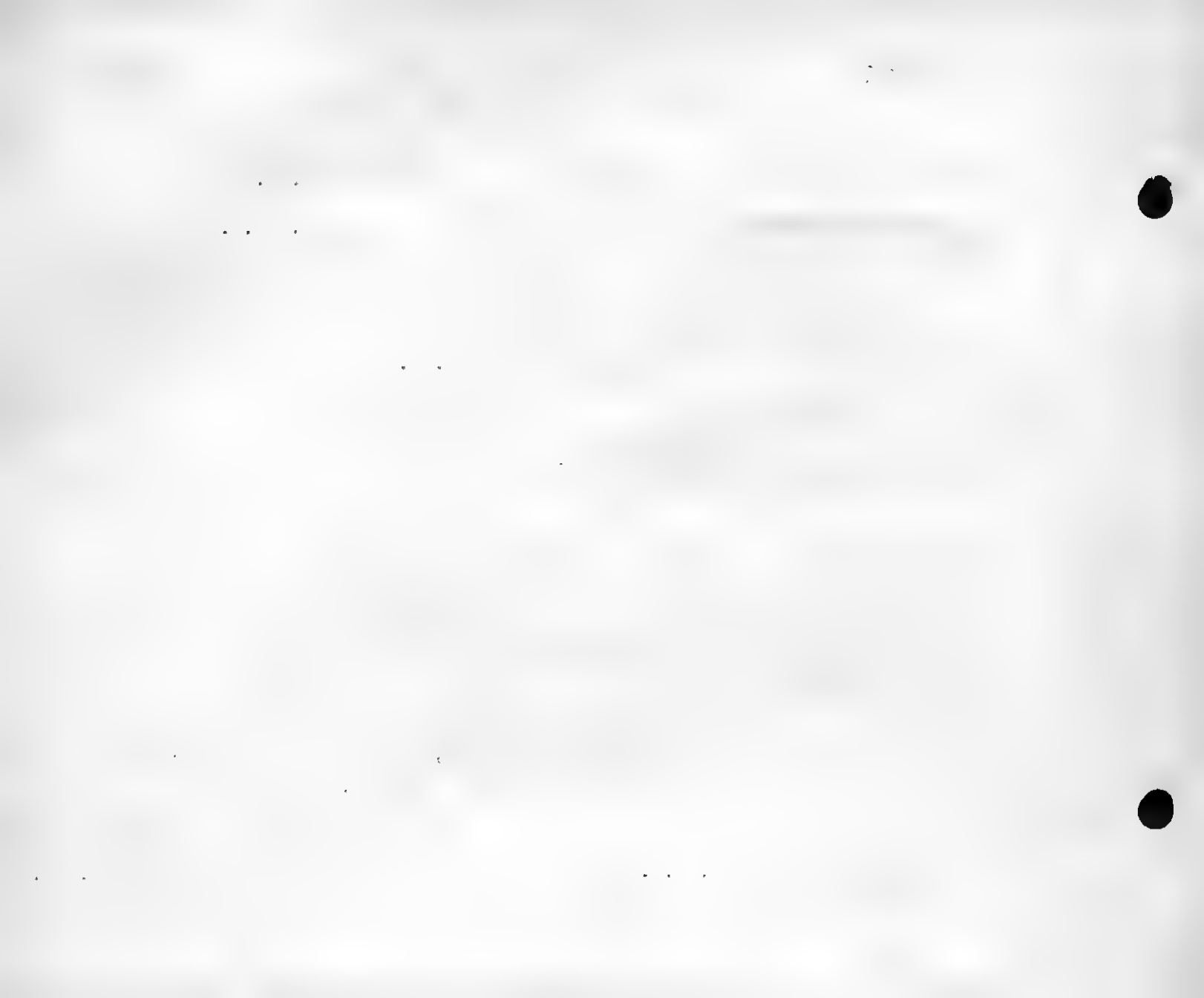
## CERTIFICATE OF DEATH

01216

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>DC</b> b. COUNTY <b>D.C.</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c LENGTH OF STAY IN 1b <b>1 mo 2 weeks</b>	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>		d. STREET ADDRESS <b>608 Chaplin St., S.E.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Lucy Means</b>		4 DATE OF DEATH Month <b>1</b> - Day <b>29</b> - Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/18/1921</b>
9 AGE (in years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>S. C.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Means</b>		14 MOTHER'S MAIDEN NAME <b>Dallas Henderson</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>238-28-3615</b>	
17 INFORMANT <b>decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Recurrent cerebrovascular accident (thrombosis)</b> DUE TO <b>Cerebral arteriosclerosis with focal encephalo-</b> <b>malacia</b> DUE TO <b>Generalized arteriosclerosis</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>unknown</b> <b>unknown</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic pyelonephritis; right hydronephrosis</b>			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/16</b> , 19 <b>66</b> , to <b>1/29/1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1/29/1967</b> , and that death occurred at <b>1:25 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>1/29/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22d. ADDRESS <b>Glenn Dale Hospital, Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>2-4-67</b>		23b. DATE THEREOF <b>2-4-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>H.S. WASHINGTON &amp; SONS</b> <b>4925 DEANE AVE. N.E.-D.C.</b>		25a. REC'D BY REGISTRAR <b>FEB 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

01219

01217

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN TB <b>22 hrs. 30 min.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institut an Residence before admn ssion) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>E. Riverdale</b> d. STREET ADDRESS <b>50720 67th Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Baby</b> Middle <b>Girl</b> Last <b>Moltz</b>		<b>4. DATE OF DEATH</b> <b>January 6, 1967</b> Month <b>January</b> Day <b>6</b> Year <b>1967</b>		<b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>1/6/67</b> <b>9. AGE</b> (In years last birthday) <b>1</b> yrs <b>6</b> mos <b>22</b> days <b>30</b> min		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of work ng life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Prince George's, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>George Edward Moltz</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>Peggy Ann Sturgess</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>			
<b>17. INFORMANT</b> <b>Mother</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meningococoele</b> <b>Congenital</b> DUE TO <b>Microcephaly</b> <b>Congenital</b> (b) <b>Microcephaly</b> <b>Congenital</b> DUE TO <b>Microcephaly</b> <b>Congenital</b> (c) <b>Microcephaly</b> <b>Congenital</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVA. BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg, etc.)			
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from Jan. 6, 1967, to Jan. 6, 1967, that (I) (we) last saw the deceased alive on Jan. 6, 1967, and that death occurred at 10:40 PM, from causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <b>John Kehoe</b> M.D.		<b>22b. DATE SIGNED</b> <b>PM</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>John Kehoe</b>			
<b>22d. ADDRESS</b> <b>6300 Riverdale Road</b> <b>Riverdale, Maryland</b>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Cremation</b> <b>23b. DATE THEREOF</b> <b>1/14/67</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Prince Georges Gen. Hosp.</b> <b>23d. LOCATION (City or Town)</b> <b>Cheverly</b> (County) <b>PG</b> (State) <b>Maryland</b>					
<b>24. FUNERAL DIRECTOR</b> <b>Harry W. Fern, Jr., Admin., Cheverly, Md.</b>		<b>25a. REC'D BY REGISTRAR</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>			
<b>DATE</b> <b>JAN 17 1967</b>		<b>DATE</b> <b>JAN 17 1967</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

VR A15ME (5)  
6M 1/67

100-2

01220

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01218

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital			d. STREET ADDRESS 5413 Odell Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last Romaine Michele Moore			4 DATE OF DEATH Month Day Year January 13 19 67		
5 SEX female	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 14, 1966	9 AGE (in years lost birthday) yrs 3 29	IF UNDER 1 YEAR Months Days Hours Mins. 3 29
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Md	
13. FATHER'S NAME Charles Moore			14. MOTHER'S MAIDEN NAME Bernadette Holsey		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. None		17. INFORMANT Bernadette Holsey Address Same as 2D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 491X IMMEDIATE CAUSE (a) Broncho-pneumonia (SDII) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)					INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 1-14-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-17-67	23c. NAME OF CEMETERY OR CREMATORY Crown		23d. LOCATION (City or Town) (County) (State) Mount Airy Md
24. FUNERAL DIRECTOR H.S. Washington & Sons 4925 Deane Ave N.E.			25a. REC'D BY REGISTRAR JAN 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01221

CERTIFICATE OF DEATH

01219

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PRINCE GEORGE'S GENERAL HOSP.</u>		e. STREET ADDRESS <u>5205 FAIR VACUUM ST.</u>	
3 NAME OF DECEASED (Type or print) <u>CLAUDE B. MORGAN</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>28</u> Year <u>1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4/22/1903</u>
9 AGE (In years last birthday) <u>63</u> yrs		10 IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hostler</u>		12 KIND OF BUSINESS OR INDUSTRY <u>Wash. Terminal</u>	
13. FATHER'S NAME <u>Mark Allen Morgan</u>		14 MOTHER'S MAIDEN NAME <u>Eliza Monroe</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>718-18-0142</u>	
17. INFORMANT <u>Mrs. Vera B. Morgan (above address)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>generalized (WTE) Carcinoma of the Esophagus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/23</u> , 19 <u>67</u> , to <u>1/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/28</u> , 19 <u>67</u> , and that death occurred at <u>2:22 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Barry Rosenberg</u>		22b. DATE SIGNED <u>Jan. 30, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Barry Rosenberg, M.D.</u>		22d. ADDRESS <u>8218 Wisconsin Ave. Bethesda, Md.</u>	
23a. BURIAL, CREMATON, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/1/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md.</u>	
24 FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 2 1967</u>	
ADDRESS <u>Mt. Rainier, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE  
HEALTH DEPT.

01222

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01220

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 5704 Queens Chapel Road	
3. NAME OF DECEASED (Type or print) First Middle Last Russell E. Mullen		4. DATE OF DEATH Month Day Year 1 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-22-86
9. AGE (in years last birthday) yrs. 80		FUNDER 1 YEAR FUNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Agriculture Dept	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank E Mullen		14. MOTHER'S MAIDEN NAME Nellie Hakes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes W W I		16. SOCIAL SECURITY NO. 22 044 8149	
17. INFORMANT Hospital records		Address Cheverly, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hematoma, left DUE TO (b) Broncho pneumonia, left, right, middle, lower lobes. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) unknown	
20c. TIME OF INJURY Month, Day, Year Hour a.m. unknown 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) unknown		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John E. Schaefer M.D., Hyattsville, Maryland		22. DATE SIGNED 1-1-67	
EXAMINER'S NAME (Type) John E. Schaefer M.D., Hyattsville, Maryland		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan 23, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REGD. BY REGISTRAR DATE JAN 27 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Jones	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Film G385 - 1/27/67 - Reported originally on  
Regular death should be H.E. - MB

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01223

## CERTIFICATE OF DEATH

01221

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN TB <b>26 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>6309 94th Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Willie</b> Middle <b>O</b> Last <b>Murphy</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>1</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>21 Mar., 1906</b>		9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maint. Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Irving Murphy</b>				14. MOTHER'S MAIDEN NAME <b>Nellie Turnage</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO <b>578-10-7827</b>		17. INFORMANT <b>Mrs. Madeline Murphy (above address)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>163X IMMEDIATE CAUSE (a) Carcinoma of Lung (Wife)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/6</b> , 19 <b>66</b> , to <b>1/1</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>1/6</b> , 19 <b>67</b> and that death occurred at <b>9:10 PM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Barry Rosenberg</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/5/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Com.</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>				ADDRESS <b>Ft. Rainier, Maryland</b>		25a. REC'D BY REGISTRAR <b>DAIAN 9 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

3 1 2  
2 2



1 1



01224

## CERTIFICATE OF DEATH

01222

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Pr. Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. LENGTH OF STAY IN TB <u>2 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		d. STREET ADDRESS <u>8839 WOODYARD RD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>15 SOUTHERN MARYLAND HOSP. CENTER</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM E. NIKODEM</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/7/01</u>
9. AGE (n years last birthday) <u>65</u> yrs		10. IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Insurance Adjuster</u>		10b. KIND OF BUSINESS OR IND. STRY <u>NEW JERSEY</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William J. Nikodem</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Buch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>ITAM #2</u>	
17. INFORMANT <u>Elizabeth I. Nikodem</u> Address <u>Same as ITAM #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>			
581.1 DUE TO <u>ENTERIC HEMMORHAGE - HEPATIC COMA</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>LAENNEC'S CIRROSI'S</u>			
(b) <u>3 DAYS</u>			
(c) <u>15 YRS.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>NONE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>NONE</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Month <u>Jan</u> Day <u>13</u> Year <u>1967</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <u>NONE</u> or while <input type="checkbox"/> at work <u>NONE</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u>NONE</u>		20f. (City or town) (County) (State) <u>NONE</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 13, 1967</u> to <u>Jan 13, 1967</u> and that death occurred at <u>7:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Arthur Shaver Jr.</u> M.D.		22b. DATE SIGNED <u>1/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR.</u>		22d. ADDRESS <u>5808 BRANCH AVE. - CLINTON MD</u>	
23a. BURIAL, CREMAT, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 17-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, DC</u>	
24. FUNERAL DIRECTOR <u>Simmons Bros.</u> ADDRESS <u>Simmons Bros.-1661-Good Hope Rd SE Wash DC</u>		25a. REC'D BY REGISTRAR <u>DATE Jan 17 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01225

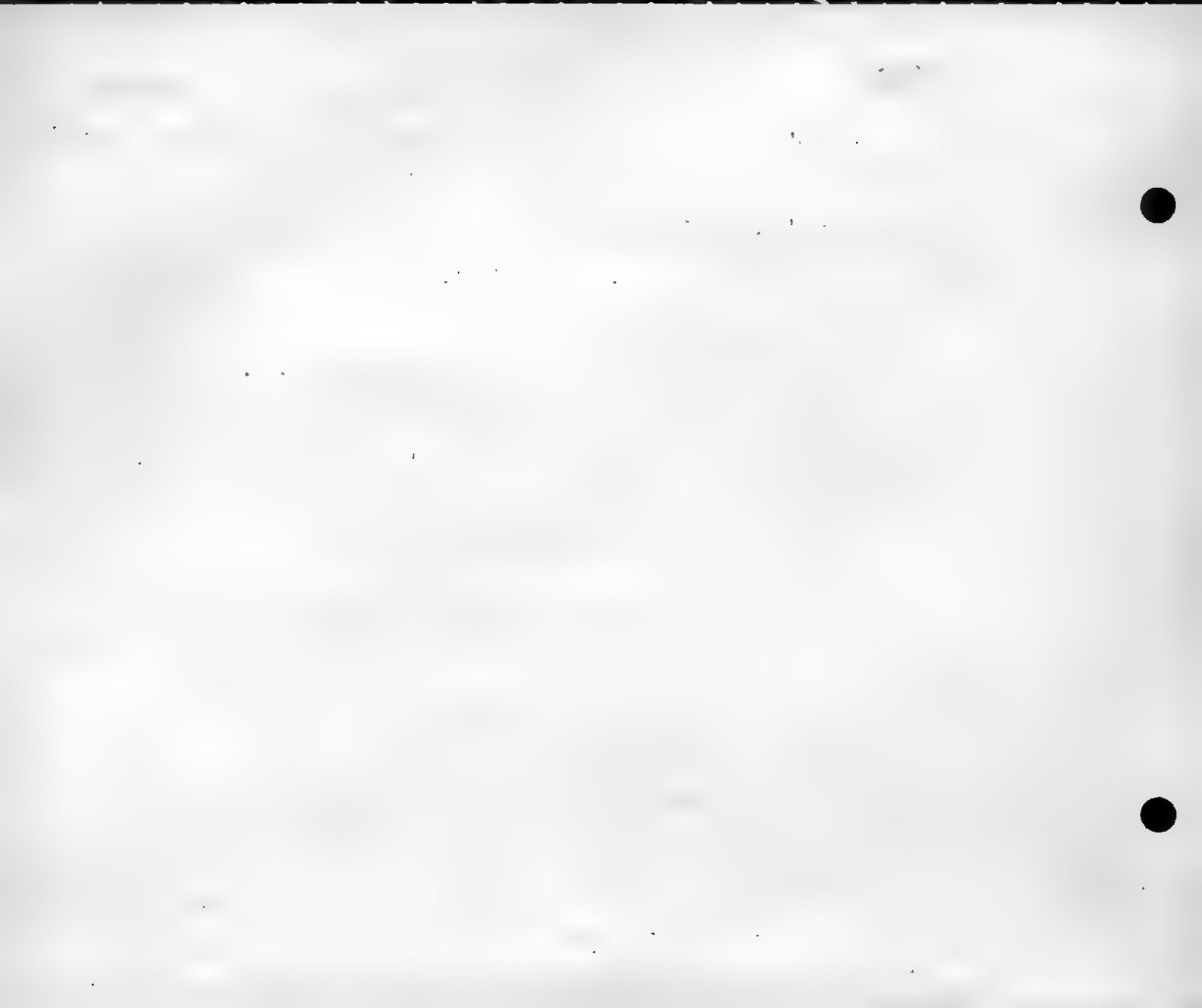
## CERTIFICATE OF DEATH

01223

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D O A</b>		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Belle Meade</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				e. STREET ADDRESS <b>4214 74th Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>J.</b> Last <b>O'Brien</b>		4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 7, 1919</b>	9. AGE (In years last birthday) <b>47</b> yrs.	10. F UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min
10a. LSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gas Station attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Esso Oil Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>	
13. FATHER'S NAME <b>Edmond O'Brien</b>			14. MOTHER'S MAIDEN NAME <b>Pearl Gray</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes W W II</b>		16. SOCIAL SECURITY NO <b>578 12 8139</b>		17. INFORMANT <b>Marie E O'Brien</b> Address <b>Belle Meade, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/9/67</b> , 19 <b>67</b> to <b>4/5/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12/18/66</b> , 19 <b>66</b> , and that death occurred at <b>4:15</b> A.M., from causes and on the date stated above.					
22a. SIGNATURE <b>F. E. Muzzey, M.D.</b>		22b. DATE SIGNED <b>4/5/67</b>		22c. PHYSICIAN'S NAME (Type) <b>F. E. Muzzey, M.D.</b>	
22d. ADDRESS <b>4410 78th Ave, Hyattsville</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan 9, 1966</b>	23c. NAME OF CEMETERY OR CREMATOR <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE M 9 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





01226

## CERTIFICATE OF DEATH

01224

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE b. COUNTY <b>Washington, D. C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 1b <b>5yrs 20 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		e. STREET ADDRESS <b>224 7th St., S.E.</b>	
3. NAME OF DECEASED (Type or print) <b>Sanders</b>		4. DATE OF DEATH Month <b>January</b> Day <b>23</b> Year <b>19 67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/6/26</b>
9. AGE (In years, last birthday) yrs <b>40</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (County & State or foreign country) <b>S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Sanders Oliver, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Mamie Robertson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>251-26-4694</b>	
17. INFORMANT <b>decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor pulmonale</b> <b>002.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO (c) <b>Pulmonary tuberculosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>18 years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1/ 3/ 19 62</b> to <b>1/ 23/ 67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1/ 23/ 67</b> , and that death occurred at <b>10:55AM</b> on causes and on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>1/23/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22d. ADDRESS <b>Glenn Dale Hospital, Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/> <b>burial</b>	23b. DATE THEREOF <b>1/29/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>East End Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Richmond Va.</b>
24. FUNERAL DIRECTOR <b>Howe's</b>		25a. REC'D BY REGISTRAR <b>1435 MARYLAND AVENUE</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JAN 30 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then the removed carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01227						01225					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
PRINCE GEORGES			MARYLAND			VA.					
c. LENGTH OF STAY IN TB			d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
HYATTSVILLE			CARROLL MANOR			ALEXANDRIA			808 JUNIOR ST		
e. IS RESIDENCE ON A FARM			f. DATE OF DEATH			g. AGE (In years last birthday)			h. IF UNDER 1 YEAR		
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			4 JAN 1967			82 yrs.			Months Days Hours Min.		
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX			6. COLOR OR RACE		
ANNA C. O'NEIL			1			FEMALE			WHITE		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH			9. AGE (In years last birthday)			10. IF UNDER 1 YEAR		
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			FEB. 24, 1884			82 yrs.			Months Days Hours Min.		
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY		
H.W.			—			SHREVEPORT, LA			U.S.A.		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
WILLIAM KINNEY						CIARA GUISE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO.					
NO						NONE					
17. INFORMANT						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
Address						INTERVAL BETWEEN ONSET AND DEATH					
SISTER M MARK, CARROLL MANOR						Longestw heart failure 4 days					
						Arteriosclerosis yes.					
						Old age					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
Coma - due to cerebral arteriosclerosis											
19. WAS AUTOPSY PERFORMED?						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY						20d. INJURY OCCURRED					
Month, Day, Year						While <input type="checkbox"/> Not While <input type="checkbox"/>					
Hour a.m. p.m.						at work <input type="checkbox"/> at work <input type="checkbox"/>					
19						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town)						20g. (County)					
(State)						(State)					
21. I certify that (I) (this hospital) attended the deceased from 5-1-1966 to 1-4-1967 that (I) (we) last saw the deceased alive on 1-2-1967, and that death occurred at 5 PM, from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED					
Richard Delaney M.D.						JAN 4, 1967					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
RICHARD DELANEY MD.						4323 HARVARD; Sil. Sp MD					
23a. BURIAL CREMATION, REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY			
BURIAL				JAN 7, 1967				Mt Albion			
24 FUNERAL DIRECTOR'S SIGNATURE				24b. ADDRESS				25a. REC'D BY REGISTRAR			
WWT altamir				3603 14th St NW				DATE			
				Wash DC 20010				JAN 9 1967			
								25b. REGISTRAR'S SIGNATURE			
								Judge			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

1 (M)

01228

CERTIFICATE OF DEATH

01226

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 19hrs.20mins.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 5613 Kennedy Street	
3. NAME OF DECEASED (Type or print*) First Middle Last Baby Girl Page		4. DATE OF DEATH Month Day Year January 18, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18, 1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 19 20
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Bearl Page		14. MOTHER'S MAIDEN NAME Helen Deanna Linkous	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Same as above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity DUE TO (b) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 18, 1967, to Jan. 18, 1967, that (I) (we) last saw the deceased alive on Jan. 18, 1967, and that death occurred at 8:45 M, from causes and on the date stated above.			
22a. SIGNATURE James E. Bell		22b. DATE SIGNED 1-19-67	
22c. PHYSICIAN'S NAME (Type) James E. Bell		22d. ADDRESS M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 1/28/67	23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hosp.	23d. LOCATION (City or Town) (County) (State) Cheverly, Maryland
24. FUNERAL DIRECTOR William A. Parker, Assist. Administrator		25a. REC'D BY REGISTRAR Charles Judge	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01223

## CERTIFICATE OF DEATH

01227

1. PLACE OF DEATH a COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Prince Georges		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c LENGTH OF STAY IN 1b 226 days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital			d STREET ADDRESS 4006 29th Street		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Herbert R. Palmer			4. DATE OF DEATH Month Day Year January 17, 19 67		
5 SEX Male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-15-97	9 AGE (n years last birthday) yrs 69	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elec. U.S. Govt.		10b KIND OF BUSINESS OR INDUSTRY -		11 BIRTHPLACE (County & State, or foreign country) Washington, D. C.	
13 FATHER'S NAME Edward Wortley			14 MOTHER'S MAIDEN NAME Mary Ellen McClain		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No -		16 SOCIAL SECURITY NO -		17 INFORMANT patient/Medical Record	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatous epirepithelioma with</u> DUE TO (b) <u>Ex-Resected carcinoma of bladder &amp; prostate</u> DUE TO (c) <u>Carcinoma of bladder 1 yr.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>March 19 67</u> to <u>1/16, 19 67</u> that (I) (we) last saw the deceased alive on <u>1/16, 19 67</u> , and that death occurred at <u>9:25 AM</u> , from causes and on the date stated above					
22a SIGNATURE <u>Francis P. Chiaramonte</u> M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) F. P. Chiaramonte, M. D.			22d. ADDRESS 4307 Branch Avenue, Marlow Heights, Md.		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 1/23/67		23c NAME OF CEMETERY OR CREMATORY Fernwood Cemetery	
				23d LOCATION (City or Town) (County) (State) Philadelphia, Penna.	
24 FUNERAL DIRECTOR Nalley's Funeral Home Inc.			ADDRESS Mt. Rainier Maryland		25a. REC'D BY REGISTRAR DATE JAN 25 1967
			25b REGISTRAR'S SIGNATURE J. Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When possible, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01230

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01228

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN IS DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		16	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 7201 24th. Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Edgar Clinton Partlow				4 DATE OF DEATH Month Day Year 1 21 19 67			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 27 March 1906	9 AGE (In years lost birthday) 60 yrs	10 IF UNDER 1 YEAR Months Days Hours Min		11 IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Star Paper		11 BIRTHPLACE (State or foreign country) Wash., D.C.		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13 FATHER'S NAME Wm. F. Partlow				14 MOTHER'S MAIDEN NAME Mary C. Gaeglee			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16 SOCIAL SECURITY NO		17 INFORMANT Mr. Robt. J. Jacobs		Address 2727-29th St., N.W., Wash., D.C.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 420.0 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)				INTERVAL BETWEEN ONSET AND DEATH minutes over 4 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				22. DATE SIGNED 1-22-67			
23a. BURIAL, CREMATION, REMOVAL, SPECIFY Burial		23b. DATE THEREOF 1/24/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d. LOCATION (City or Town) (County) (State) Wash., D.C.	
24. FUNERAL DIRECTOR Nailey's Funeral Home Inc.				ADDRESS Maryland Rainier		25a. REC'D BY REG STRAR DATE JAN 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge							



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01231

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01229

1 PLACE OF DEATH a COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c LENGTH OF STAY N 1b <b>3 days</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d STREET ADDRESS <b>1014 60th. Place</b>	
3 NAME OF DECEASED (Type or print) <b>Mansfield</b>		4 DATE OF DEATH Month <b>1</b> Day <b>31</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>5 Sept. 1916</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (In years lost birthday) yrs <b>50</b>
13 FATHER'S NAME <b>Son Payton</b>		14 MOTHER'S MAIDEN NAME <b>Ellen Watson</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <b>579-14-9928</b>	
17 INFORMANT <b>Ernest Payton - Brother</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain laceration, temporal lobes, bilateral</b> DUE TO <b>And sub-dural hematoma, right, massive</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>From trauma</b> (b) <b>From trauma</b> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) <b>unknown</b>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>9:00am</b> p.m. <b>1-26- 67</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>
20f (City or town) <b>same as #2</b>		(County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		22. DATE SIGNED <b>2-1-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <b>2-6-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d LOCATION (City or town) (County) (State) <b>Arlington Va.</b>
24 FUNERAL DIRECTOR <b>Rev. Brooks &amp; Allen Funeral Home</b>		25a REC'D BY REGISTRAR <b>W. N. S. C.</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>
DATE <b>FEB 3 1967</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01232

## CERTIFICATE OF DEATH

01230

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c LENGTH OF STAY in lb <b>7 days</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d STREET ADDRESS <b>2703 Parkway Place</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>John B Perkins</b>		4 DATE OF DEATH Month Day Year <b>Jan 18 1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>12 Oct., 1896</b>
9 AGE (In years last birthday) <b>70 yrs</b>		10 IF UNDER 1 YEAR Months Days Hours Min. <b>18 19 67</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b KIND OF BUSINESS OR IND. STRY <b>Paymaster G P O</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>South Dakota</b>		12 CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John C Perkins</b>		14. MOTHER'S MAIDEN NAME <b>Lillian P Woods</b>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>		16 SOCIAL SECURITY NO <b>220 448 705 T</b>	
17 INFORMANT <b>Frances M Perkins</b>		Address <b>Cheverly, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1 Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Emphysema of Lungs</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>5 yrs</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 1958</b> , to <b>JAN 18, 1967</b> , that (I) (we) last saw the deceased alive on <b>JAN 18 1967</b> , and that death occurred at <b>6:00AM</b> , from causes and on the date stated above			
22a SIGNATURE <b>Norman D. Comeau</b> M.D.		22b DATE SIGNED <b>1/18/67</b>	
22c PHYSICIAN'S NAME (Type) <b>NORMAN D. COMEAU</b>		22d ADDRESS <b>3503 Penzance Rd. ANNAPOLIS Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>Jan 20, 1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 23 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01233

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01231

1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY in 1b <u>DOA</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>			d. STREET ADDRESS <u>3100 Taylor Street</u>		
3 NAME OF DECEASED (Type or print) First Middle Last <u>Elsie Pearl Pfeleeger</u>			4 DATE OF DEATH Month Day Year <u>1 10 19 67</u>		
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/24/1895</u>	9 AGE (in years) <u>71</u> yrs	FUNERAL 1 YEAR Months Days FUND 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Div. Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>		11 BIRTHPLACE (State or foreign country) <u>Penna.</u>	
13 FATHER'S NAME <u>Osmer Anderson</u>			14. MOTHER'S MAIDEN NAME <u>Hannah G. Anderson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv.) <u>No</u>		16 SOCIAL SECURITY NO. <u>219-42-3930</u>		17. INFORMANT Address <u>Mr. Clarence A. Pfeleeger Route #1 Sharpshurg, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxiation</u> <u>774X</u> DUE TO <u>Hanging</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Hanged self in basement of home</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>1-10-67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Basement of home</u>	20f. (City or town) <u>same as #2</u>	(County) (State)	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.			22. DATE SIGNED <u>1-11-67</u>		
EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u> Riverdale, Md.			Address (Street, city, town, or county)		
23a. BURIAL (CREMATION, REMOVAL) (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mountain View Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Sharpshurg, Md.</u>	
24 FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>			ADDRESS <u>Mt. Rainier, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 17 1967</u>
			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		





01234

## CERTIFICATE OF DEATH

01232

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb 368 1/2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 3572 Dean Drive	
3. NAME OF DECEASED (Type or print) First John Middle H. Last Preisler		4. DATE OF DEATH Month J Year 12 Day 12 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-8-86
9. AGE (in years last birthday) 81 yrs		10. FUND 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Linotyper		10b. KIND OF BUSINESS OR INDUSTRY Printing	
11. BIRTHPLACE (County & State, or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James C. Preisler		14. MOTHER'S MAIDEN NAME Frances Wertz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes give war or dates of service) no		16. SOCIAL SECURITY NO 159 03 6848	
17. INFORMANT Roy P. Buckwalter		6216 1st Ave. Hyattsville, Md. Nephew	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 MONTH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-7, 1966, to 1-12, 1967, that (I) (we) last saw the deceased alive on 1-11, 1967, and that death occurred at 7:00 AM, from causes and on the date stated above.			
22a. SIGNATURE C. J. Heumann		22b. DATE SIGNED 1-11-67	
22c. PHYSICIAN'S NAME (Type) C. J. Heumann		22d. ADDRESS RIVERDALE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 1/14/67	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JAN 16 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



01235

CERTIFICATE OF DEATH

01233

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Res'dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>		d. STREET ADDRESS <b>4311 Rowalt Drive</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George County General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Leland</b> Middle <b>S.</b> Last <b>Pyle</b>		4. DATE OF DEATH Month <b>January</b> Day <b>6</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-8-1904</b>
9. AGE (in years last birthday) <b>62</b> yrs		10. F UNDER 1 YEAR Months <b>16</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Apartment House</b>	
11. BIRTH PLACE (County & State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Frank Pyle</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Semple</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes</b> <b>W W 11</b>		16. SOCIAL SECURITY NO <b>236 12 5484</b>	
17. INFORMANT <b>Peggy L. Pyle</b>		Address <b>College Park, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b> DUE TO (b) <b>arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1-2-1967</b> , to <b>1-2-1967</b> , that (I) (we) last saw the deceased alive on <b>1-2-1967</b> , and that death occurred at <b>4:50 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>W.C. WEINTRAUB</b>		22b. DATE SIGNED <b>Jan. 6 - 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>W.C. WEINTRAUB</b>		22d. ADDRESS <b>Greenbelt, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan 10, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Va.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>JAN 11 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



01236

## CERTIFICATE OF DEATH

01234

1 PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>HYATTSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>	
c. LENGTH OF STAY IN 1b <b>6 mos.</b>		d. STREET ADDRESS <b>4411 38th. ST. N.W.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HYATTSVILLE NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>ALICE J. REARDON</b>		4. DATE OF DEATH Month <b>1-</b> Day <b>27-</b> Year <b>19 67</b>	
5 SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>7-26-81</b>
9 AGE (In years last birthday) <b>85 yrs.</b>		11. BIRTHPLACE (County & State or foreign country) <b>MASS.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT.</b>		13. FATHER'S NAME <b>JEFFREY O'CONNELL</b>	
14. MOTHER'S MAIDEN NAME <b>CATHERINE DALEY</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16 SOCIAL SECURITY NO.		17 INFORMANT <b>MRS. PATRICK WINSTON SAME AS #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL FAILURE</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-13, 19 64</b> to <b>1-27</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>1-26</b> , 19 <b>67</b> and that death occurred at <b>1 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Robert R. Hottel</i>		22b. DATE SIGNED <b>1-27-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT R. HOTTEL, M.D.</b>		22d. ADDRESS <b>1222 MONROE ST. N.E. WASH. D.C.</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-30-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT OLIVET CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON, D. C.</b>	
24. FUNERAL DIRECTOR <i>F. J. Collins</i> <b>FRANCIS J. COLLINS 3821</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 30 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

01237

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01235

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>205 Audrey Lane SE</b>	
3 NAME OF DECEASED (Type or print) <b>Sara White Ricker</b>		4 DATE OF DEATH Month <b>1</b> Day <b>19</b> Year <b>19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>7-12-1916</b>
9 AGE (In years last birthday) <b>50</b> yrs		10 IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>67</b> Min <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret'd</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Gov't.</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Timothy White</b>		14 MOTHER'S MAIDEN NAME <b>Bridgett O'Hara</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>Same as Item #2</b>	
17 INFORMANT <b>Bernard H. Ricker</b>		Address <b>Same as Item #2</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>pulmonary edema</b> <b>3d.d.d</b> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>Aspiration of gastric contents</b> DUE TO (c) <b>Intoxication - ethyl alcohol</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office, b.g., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>1-20-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 23-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>Simmons Bros.</b>		25a. REC'D BY REGISTRAR <b>JAN 23 1967</b>	
Address <b>Simmons Bros. 1661-Good Hope Rd SE Wash DC</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

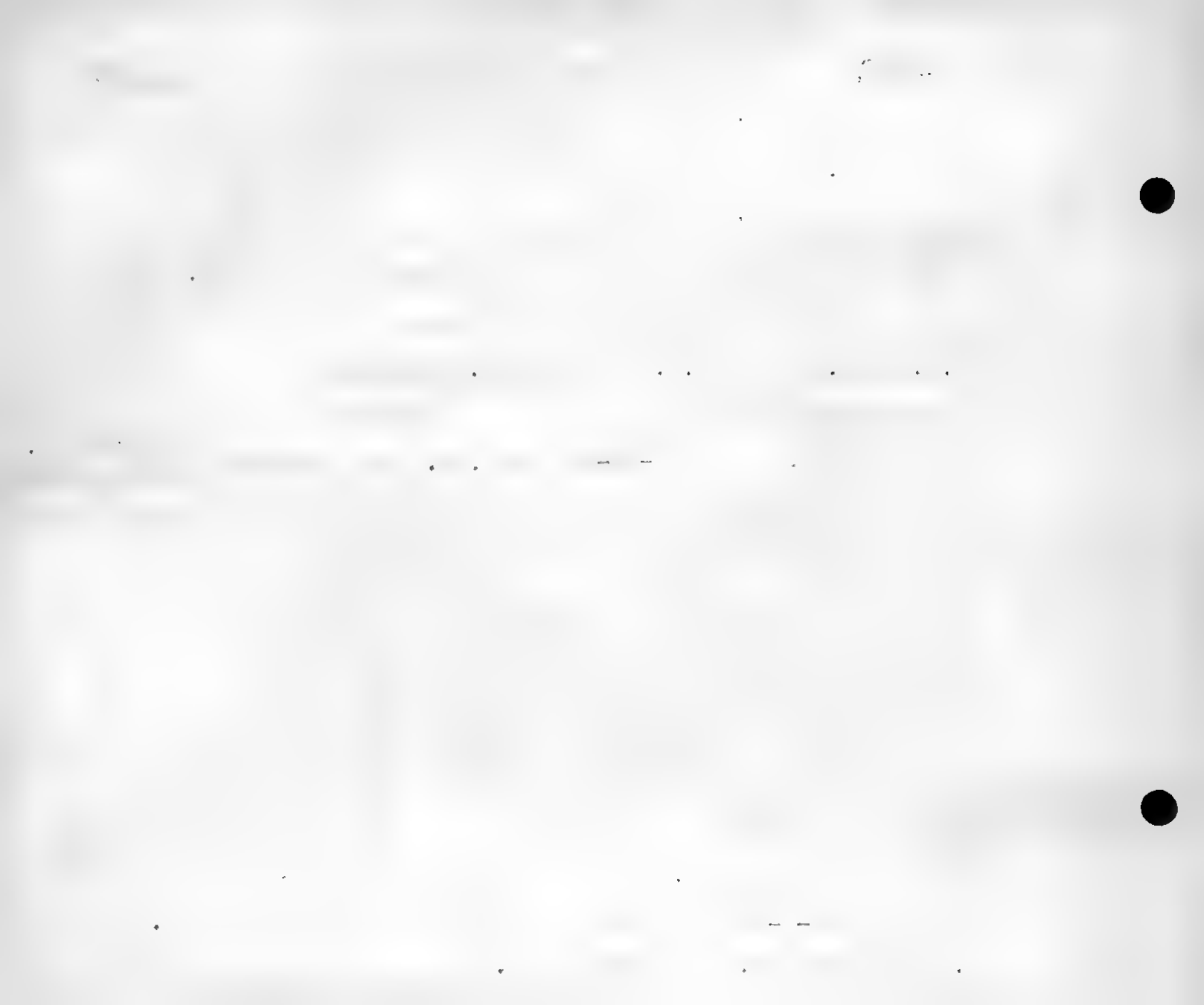
1

01238

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01236

1 PLACE OF DEATH a COUNTY <u>Prince George's</u> <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince George's</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c LENGTH OF STAY IN 1b <u>DOA</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's Hospital</u>		d. STREET ADDRESS <u>Potomac Street</u>	
3 NAME OF DECEASED (Type or print) <u>Robert Earl Rickerson</u>		4 DATE OF DEATH Month <u>Jan.</u> Day <u>1</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>March 1, 1927</u>
9 AGE (in years last birthday) <u>39</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) <u>T.V. Tech.</u>	
11. BIRTHPLACE (State or foreign country) <u>Oklahoma</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oscar Rickerson</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW II</u>		16 SOCIAL SECURITY NO <u>448-22-4510</u>	
17 INFORMANT <u>Mrs. V. Jean Rickerson</u>		Address <u>Potomac St. Glenn Dale, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pulmonary edema, Bilateral, severe</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Etiology undetermined</u> (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		22. DATE SIGNED <u>1-2-67</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u>		Address (State, city, town, or county) <u>Riverdale, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-5-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>
24 FUNERAL DIRECTOR <u>W.W. Chambers Co.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Riverdale, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JAN 6 1967</u>			



01239

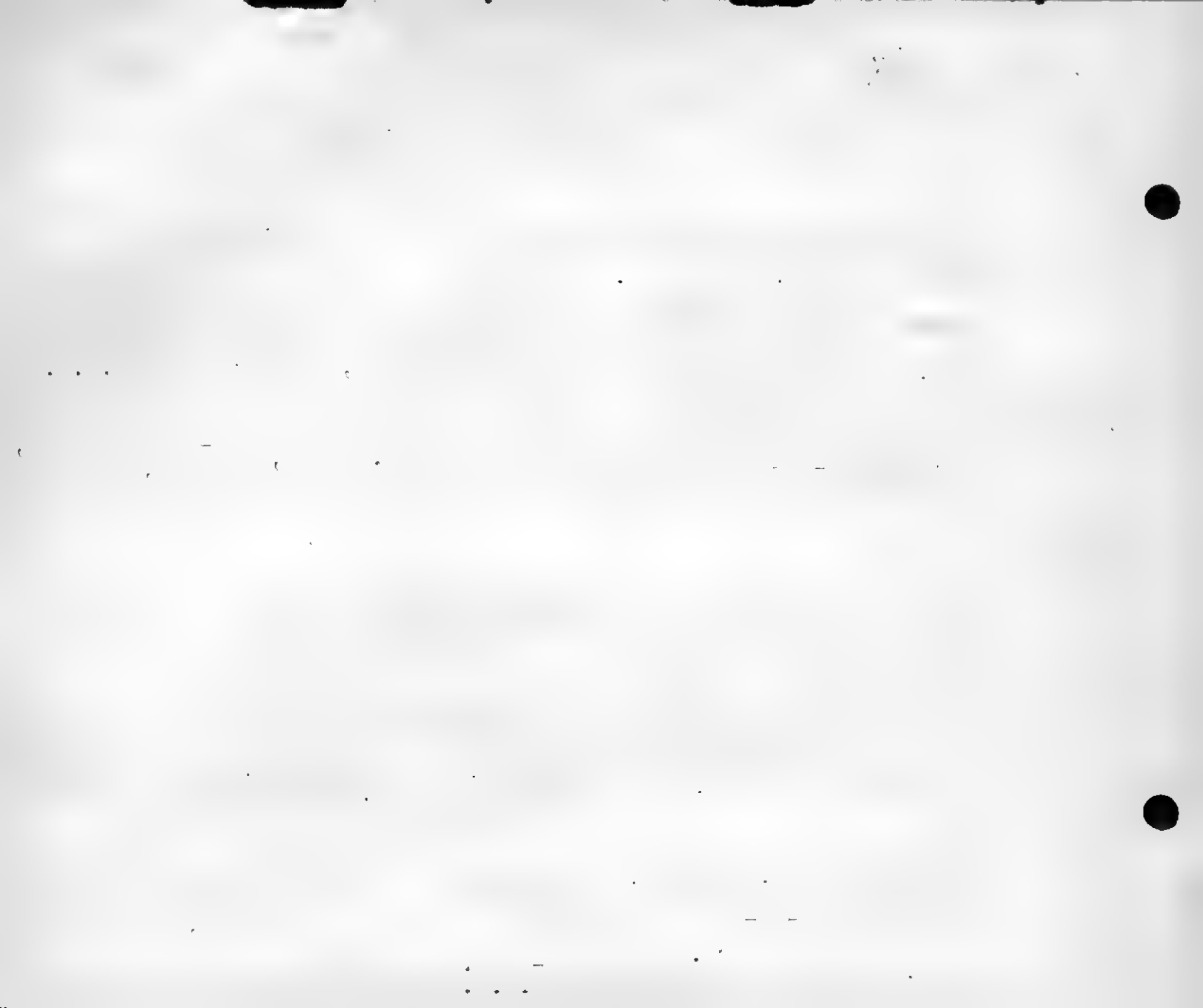
CERTIFICATE OF DEATH

01237

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>1 hr</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b> d. STREET ADDRESS <b>8305 Ardmore Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Viola C. Rodill</b>		4. DATE OF DEATH Month Day Year <b>Jan 12 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 May 1905</b>
9. AGE (In years last birthday) <b>61</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min <b>7 20</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H/W. Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Leesburg, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas McDonough</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT (Husband) <b>Marcelino H. Rodill</b>		18. ADDRESS <b>8305-Ardmore Road, Landover Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>Jan. 12, 1967</b> , to <b>Jan. 12, 1967</b> , that <del>the</del> (we) last saw the deceased alive on <b>Jan. 12, 1967</b> , and that death occurred at <b>2:50 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Edwin J. Jensen</b>		22b. DATE SIGNED <b>Jan. 12, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>		22d. ADDRESS <b>Prince George's General Hospital Cheverly, Maryland</b>	
23a. BURIAL CREMATION <b>BURIAL</b>		23b. DATE THEREOF <b>1-16-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Per: J. Hysong Fun. Home</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 13 1967</b>	
ADDRESS <b>1300-N St. NW Wash. D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01240

CERTIFICATE OF DEATH

01238

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN TB D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>5607 37th Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Katherine V. Rogers</b> First Middle Last				4. DATE OF DEATH <b>Jan 10 1967</b> Month Day Year			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-1-23</b>	
9. AGE (In years last birthday) <b>49</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		11. BIRTHPLACE (County & State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Salvatore Waterholter</b>				14. MOTHER'S MAIDEN NAME <b>Alice M. Linguson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>577 26 4321</b>		17. INFORMANT <b>John S. Degen Hyattsville, Md</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>1750</b> IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO (b) <b>Bilateral ovarian carcinoma</b> DUE TO (c) <b>(serous cystadenoma)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>7 mos</b> <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-23</b> , 1966, to <b>1-10</b> , 1967, that (I) (we) lost saw the deceased alive on <b>1-7</b> , 1967, and that death occurred at <b>5:35 A.M.</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Jeanne C Bateman MD</b>				22b. DATE SIGNED <b>1-11-67</b>		22c. PHYSICIAN'S NAME (Type) <b>Jeanne C. Bateman, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 13, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington Montgomery Md</b>	
24. FUNERAL DIRECTOR <b>J. Haskis, Sons Hyattsville Md</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
				DATE <b>JAN 16 1967</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01241

## CERTIFICATE OF DEATH

01239

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>5 hours</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Coral Hills</b> d. STREET ADDRESS <b>5321 R Street</b> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>James F. Rothenberg</b>		4 DATE OF DEATH Month Day Year <b>January 16 19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>7/24/1912</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Delicatessen Store</b>	9 AGE (In years last birthday) yrs. <b>54</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes WW II</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Dorothy A. Rothenberg (Wife)</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart disease with acute right thrombosis.</b> DUE TO (b) <b>Myocardial Infarction</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>1/16</b> , 19 <b>67</b> , to <b>1/16</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1/16</b> , 19 <b>67</b> , and that death occurred at <b>3:25 M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>Edwin J. Jensen</b>		22b. DATE SIGNED <b>P.M.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen</b>		22d. ADDRESS <b>Prince George's General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 20-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery - Arlington, Virginia</b>	23d. LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR <b>Summons Bros.</b>		25a. REC'D BY REGISTRAR <b>JAN 20 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>James J. J.</b>		25c. REGISTRAR'S NAME <b>James J. J.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01242

CERTIFICATE OF DEATH

01240

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chapel Oaks</b> <b>16-1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>5313 Addison Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elsie</b> Middle <b>Ruffin</b> Last <b>Ruffin</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>30</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1911</b> <b>25 June 1911</b>	9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min <b></b>		IF UNDER 24 HRS. Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Richmond Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Aticos Moyer</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Niece</b> Address <b>Ch Oaks</b> <b>Estelle Anderson 5321 Chapel Lane</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Vascular Hypertension</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1) Diabetes Mellitus 2) Coronary Arteriosclerotic Heart Disease</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>Jan. 25</b> , 19 <b>67</b> , to <b>Jan. 30</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Jan. 30</b> , 19 <b>67</b> , and that death occurred at <b>12:20 AM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Edwin J. Jensen</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M.D.</b>				22d. ADDRESS <b>Prince Georges General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>2-3-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Nat. Harmony</b>		23d. LOCATION (City or Town) (County) (State) <b>Highland Park Md</b>	
24. FUNERAL DIRECTOR <b>H.S. Washington &amp; Sons 4925 Penna Ave NW</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01243

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01241

1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>7170 Fort Foote Road</u>	
3 NAME OF DECEASED (Type or print) <u>Marie E Russell</u>		4 DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-26-1896</u>
9 AGE (In years lost birthday) <u>70</u> Yes		10 IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US. Gov.</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Cavanaugh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>1208- Jackson Ave.,</u>	
17 INFORMANT <u>William F. Langley</u>		Address <u>Takoma Park, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>Hypertensive arteriosclerotic heart disease</u> (b) _____ DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>over 1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o</u> m <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		22. DATE SIGNED <u>1-2-67</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>Jan. 5-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>Simmons Brothers</u>		25a. REC'D BY REGISTRAR <u>JAN 4 1967</u>	
ADDRESS <u>1661-Gd. Hope Rd. SE. Wash., DC</u>		25b. REGISTRAR'S SIGNATURE <u>Judge</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

FOR STATE  
HEALTH DEPT.

01244

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01242

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if inst. l.t. on Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seabrook		161	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 5417 Ellerbie Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Evelyn Virginia Sanders				4. DATE OF DEATH 7 1 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-1942	9. AGE (In years last birthday) 24 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired) HOUSEWIFE & SECT		10b. KIND OF BUSINESS OR INDUSTRY PUBLIC ROADS		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME WILLIAM B. MARTIN				14. MOTHER'S MAIDEN NAME VESTA RUTH COLEBANK			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 232-68-3687		17. INFORMANT LESLIE H. SANDERS		Address SEE # 2 ABCD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 332X Cerebral thrombosis DUE TO (b) Cause undetermined DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.		EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 1-2-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-5-66		23c. NAME OF CEMETERY OR CREMATORY DENVER CEMETERY		23d. LOCATION (City or town) (County) (State) DENVER, U.S.A.	
24. FUNERAL DIRECTOR ADDRESS W W CHAMBERS Co RIVERDALE, MD				25a. REC'D BY REGISTRAR DATE JAN 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in the space provided for the cause of death. 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

01245

Items #11 & 12

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01243

1. PLACE OF DEATH a COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince George's</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c LENGTH OF STAY IN 1b <u>DOA</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>				a STREET ADDRESS <u>1007 Addison Road</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Marvin Sanders</u>				4 DATE OF DEATH Month Day Year <u>1 19 67</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>2 April 1890</u>		9 AGE (In years last birthday) yrs <u>76</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Tuscaloosa, Alabama</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME				14 MOTHER'S MAIDEN NAME			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO		17 INFORMANT Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>Arteriosclerotic heart disease</u> (b) _____ DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>over 10 yrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D. EXAMINER'S NAME (Type) <u>John Kehoe, M.D., Riverdale, Md.</u>				22. DATE SIGNED <u>1-2-67</u>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF <u>1/6/66</u>		23c NAME OF CEMETERY OR CREMATORY <u>Lincoln Cemetery</u>		23d LOCATION (City or town) (County) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Howard T. Boyd</u> <u>London T. Boyd</u>				25a REC'D BY REGISTRAR <u>5228th St. S.E.</u> <u>Wash. D.C.</u>		25b REGISTRAR'S SIGNATURE <u>Jan 9 1967</u>	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01246

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01244

1. PLACE OF DEATH a COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Oaks</u>		161	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>				d STREET ADDRESS <u>1500 Oak Street</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Sammy</u> Middle <u>Loy</u> Last <u>Sanders</u>				4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>male</u>		6 COLOR OR RACE <u>Negro</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>June 9, 1938</u>	
9. AGE (In years last birthday) <u>27</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of work ing life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Helper</u>		11 BIRTHPLACE (State or foreign country) <u>Chester S.C.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13 FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Melene Sanders</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> <u>None</u>				16 SOCIAL SECURITY NO <u>  </u>		17. INFORMANT <u>Delores Sanders</u> Address <u>2412 E. Vanns Rd. S.E.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>							
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>			
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kekoa E.D., Liverdale, Maryland</u>				22. DATE SIGNED <u>1-2-67</u>			
EXAMINER'S NAME (Type) <u>John Kekoa E.D., Liverdale, Maryland</u>				Address (Street, city, town, or county) <u>  </u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>1-6-67</u>		23b DATE THEREOF <u>1-6-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Rosspect Ch. Cem.</u>		23d LOCATION (City or Town) (County) (State) <u>Chester S.C.</u>	
24. FUNERAL DIRECTOR <u>H.S. Washington &amp; Sons 4925 Jennie Ave NE.</u>				25a REC'D BY REGISTRAR DATE <u>JAN 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John A. Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01247

## CERTIFICATE OF DEATH

01245

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillcrest Heights</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Regent Nursing Home</b>						d. STREET ADDRESS <b>5510 22nd Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CARIE M. SANFORD</b>				4. DATE OF DEATH Month Day Year <b>Feb 30 1967</b>					
5 SEX <b>female</b>		6 COLOR OR RACE <b>white</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>5/1/1877</b>		9. AGE (In years, age birthday yrs) <b>89</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Buyer- Julius Garfinckel</b>				10b KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Charles Sanford</b>						14. MOTHER'S MAIDEN NAME <b>Sarah Mannakee</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>578-07-0671</b>		17. INFORMANT Address <b>Helen T. Hughes, (same as #2)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular thrombosis</b> 332X DUE TO <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Winny years</b> (c)								INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-30</b> , 1967, to <b>1-30</b> , 1967, that (I) (we) last saw the deceased alive on <b>1-30</b> , 1967, and that death occurred at <b>10:30</b> A.M. from causes and on the date stated above.									
22a. SIGNATURE <b>W.B. Sheer</b>						M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-30-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER B. SHEER</b>						22d. ADDRESS <b>6400 MARLBORO PIKE SE. WASH. D.C. 20028</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>2/2/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>			
24. FUNERAL DIRECTOR <b>Wm. H. Hines Co. Wash, D.C.</b>						25a REC'D BY REGISTRAR DATE <b>FEB 2 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

01248

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01246

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Union</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tantallon -Oxon Hill</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Moorestown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>12205--Hollybank Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>MARTHA</b> Last <b>SAUERBRUNN</b>		4 DATE OF DEATH Month <b>January</b> Day <b>3rd</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Nov. 25-1881</b>
9. AGE (in years last birthday) <b>85 yrs</b>		F UNDER 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 Hrs Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Elizabeth, New Jersey</b>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <b>John Jacob Sauerbrunn</b>		14 MOTHER'S MAIDEN NAME <b>Margaret Reuter</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <b>152-03-0768 A</b>	
17 INFORMANT <b>Rev. Edward Daley</b>		Address <b>Same as Item #2</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO (b) <b>Arterio Sclerotic Heart Disease</b> DUE TO (c) <b>lost.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John A. Kehoe</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. John A. Kehoe</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED <b>Jan. 3rd 1967</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 5-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ever Green Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Elizabeth, New Jersey</b>
24 FUNERAL DIRECTOR <b>Simmons Bros.-1661-Good Hope Rd SE Wash DC</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 4 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Judge</b>	



# 1 M 71 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit and please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01249

## CERTIFICATE OF DEATH

01247

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>5 hours</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		d. STREET ADDRESS <b>Baltimore 21228</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>H</b> Last <b>Schaub</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>7</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-3-12</b>
9. AGE (in years) <b>54</b> (1st birthday) yrs		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b> Hours <b>67</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mutuel clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Race tracks</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Francis Schaub</b>		14. MOTHER'S MAIDEN NAME <b>Rose May Dressler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>World war 2</b>		16. SOCIAL SECURITY NO. <b>212-01-4224</b>	
17. INFORMANT <b>Mrs. Margaret G. Schaub</b>		Address <b>2200 Posers Lane</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Recent Intra-Portine Hemorrhage</b> DUE TO (b) <b>33IX</b> DUE TO (c) <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 7 1967</b> , to <b>Jan 7 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan 7 1967</b> , and that death occurred at <b>7 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>J. A. Garcia M.D.</b>		22b. DATE SIGNED <b>1/8/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. A. Garcia M.D.</b>		22d. ADDRESS <b>Prince George Hospital Cheverly, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/11/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Easton Funeral Home</b>		ADDRESS <b>Catonsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>JAN 12 1967</b>			





01250

CERTIFICATE OF DEATH

01248

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN lb 4 mos., 3 wks.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e. STREET ADDRESS 100 I St., N. W.	
3 NAME OF DECEASED (Type or print*) First Thomas Middle E. Last Seigler		4 DATE OF DEATH Month 1 Day 3 Year 19 67	
5 SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> separated <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/27/1923
9 AGE (n years last birthday) yrs 43		10. IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		10b. KIND OF BUSINESS OR INDUSTRY ---	
11 BIRTHPLACE (County & State, or foreign country) South Carolina		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas L. Seigler		14. MOTHER'S MAIDEN NAME Margaret Harrison	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 249-32-4735	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiolar carcinoma, right lung with DUE TO widespread metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (s) (this hospital) attended the deceased from 8/12/19 66, to 1/3/19 67, that (s) (we) last saw the deceased alive on 1/3/19 67, and that death occurred at 8:45 PM, from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 1/3/1967	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-9-67	
23c. NAME OF CEMETERY OR CREMATORY HARMONY PARK		23d. LOCATION (City or Town) (County) (State) LANDOVER, MD.	
24. FUNERAL DIRECTOR ROLLINS, INC. 4339 HUNT PLACE, NE.		25a. REC'D BY REGISTRAR DATE JAN 9 1967	
		25b. REGISTRAR'S SIGNATURE Judge	



CERTIFICATE OF DEATH

01251

01249

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HILLCREST HEIGHTS</b> c. LENGTH OF STAY IN 1b <b>12</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HILLCREST HEIGHTS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5853 28th AVENUE</b>		d. STREET ADDRESS <b>5853 28th AVENUE</b>	
3. NAME OF DECEASED (Type or print) <b>TANYA SELINSKY</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>14</b> Year <b>19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 13, 1966</b>
9. AGE (In years, last birthday) <b>4</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DEPENDENT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WASHINGTON D.C.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN SELINSKY</b>		14. MOTHER'S MAIDEN NAME <b>JEAN RIFFLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>SAME AS #2</b>	
17. INFORMANT <b>JEAN R. SELINSKY</b>		Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY <b>474X</b> IMMEDIATE CAUSE (a) <b>Respiratory obstruction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Croup</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-8-66</b> to <b>1-14-67</b> that (I) (we) last saw the deceased alive on <b>1-13-67</b> , and that death occurred at <b>8:30 AM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>David Gordon</b>		22b. DATE SIGNED <b>1-14-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>David Gordon</b>		22d. ADDRESS <b>M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/17/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>EAST OAK GROVE CEMETERY</b>		23d. LOCATION (City or town) (County) (State) <b>MORGANTOWN WEST VIRGINIA</b>	
24. FUNERAL DIRECTOR <b>WILHELM FUNERAL HOME</b>		25a. REC'D BY REG. STRAR <b>DATE JAN 19 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01252

CERTIFICATE OF DEATH

01250

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesverly</b>		c. LENGTH OF STAY IN lb <b>39 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>3213 75th Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>C</b> Last <b>Shane</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>23</b> Year <b>19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>19 May 1879</b>		9. AGE (In years last birthday) <b>87 yrs.</b>	10. IF UNDER 1 YEAR Months <b>16</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>FREDERICK MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>JOHN D WRIGHT</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH BITTINGER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-09-5477</b>		17. INFORMANT <b>HELEN I POOLE</b> Address <b>3213-75th Ave Landover Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> DUE TO <b>Coronary atherosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pneumonia</b> DUE TO (c) <b>Pneumonia</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/15</b> , 19 <b>66</b> to <b>1/23</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1/22</b> , 19 <b>67</b> , and that death occurred at <b>30AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Max M. Herzberg</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Jan. 24, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Max M. Herzberg, M.D.</b>				22d. ADDRESS <b>3308 Dodge Pk. Rd. Landover, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-26-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery Prince Georges Md.</b>		23d. LOCATION (City or Town) (County) (State) <b>Landover Md.</b>	
24. FUNERAL DIRECTOR <b>H.W. Chambers</b>				ADDRESS <b>6-517-11th St SE Wash D.C.</b>		25. REC'D BY REGISTRAR <b>JAN 27 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01253

## CERTIFICATE OF DEATH

01251

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 1023 7th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DAVID First Middle H. Sisson Last David		4. DATE OF DEATH January 19, 1967	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 31, 1879	
9. AGE (In years last birthday) 87 Yrs		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt Farm Doctor Indian	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Sisson		14. MOTHER'S MAIDEN NAME Serepta Robinson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. David Sisson Laurel Md.		Address 1023 7th St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Myocardial Infarction DUE TO (b) Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Atherosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Upper Gastrointestinal Bleeding, Missed, Embolus?		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 9, 1967, to Jan. 19, 1967, that (I) (we) last saw the deceased alive on Jan. 19, 1967, and that death occurred at 6 A.M. from causes and on the date stated above			
22a. SIGNATURE M. P. Farzin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) M. P. Farzin, M.D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-21-67	
23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City or Town) (County) (State) Burtonville Md	
24. FUNERAL DIRECTOR		25. REC'D BY REGISTRAR	
25a. ADDRESS		25b. REGISTRAR'S SIGNATURE	
DATE JAN 31 1967		J. H. Jones, Judge	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. **THEM PLEASE REMOVE CARBON PAPERS.** Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01252

FOR STATE  
HEALTH DEPT.

01254

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights		1601	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 6226 Kingston Road			
3 NAME OF DECEASED (Type or print) Edwin Forest Smith				4 DATE OF DEATH 1 19 1967			
5 SEX Male		6. CO. OR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 7-13-1903	
9 AGE (In years last birthday) 63 yrs.		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b KIND OF BUSINESS OR INDUSTRY GIANT FOODS		11 BIRTHPLACE (State or foreign country) CHESTER, PENNA	
12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edwin F. Smith.		14. MOTHER'S MAIDEN NAME ELIZABETH FAYE			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16 SOCIAL SECURITY NO UNKNOWN		17 INFORMANT ANNA C. SMITH Address SEE # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Right coronary thrombosis DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D. Riverdale, Md.				22. DATE SIGNED 1-20-67			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 1/24/67		23c NAME OF CEMETERY OR CREMATORY WASH. NAT'L CEM.		23d LOCATION (City or town) (County) (State) SEITLAND, MD.	
24 FUNERAL DIRECTOR W.L. Chambers Co., Inc. Address SEE # 2				25a REC'D BY REGISTRAR JAN 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

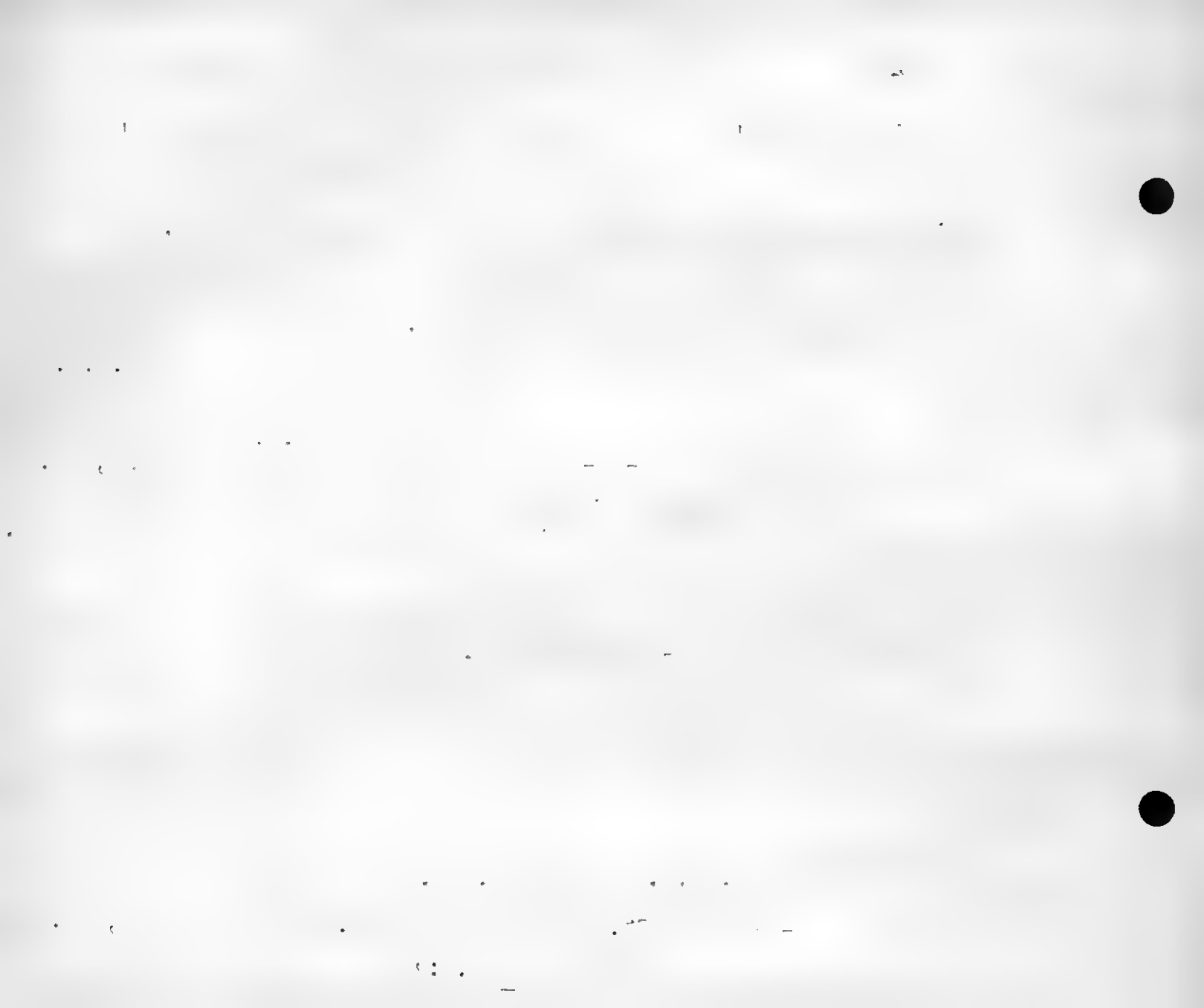
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01255

01253

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>Box 4253 Dowerhouse Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>Katie Rebecca Spencer</b>		4. DATE OF DEATH Month <b>1</b> Day <b>3</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 Feb. 1891</b>
9. AGE (In years lost birthday) <b>75</b> yrs		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>19</b> Hours <b>67</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Hawkins</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Marshall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>215-54-5197</b>	
17. INFORMANT <b>R.F.D. 1329</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST (b) _____ (c) _____	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus - over 5 years.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		22. DATE SIGNED <b>1-3-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>1-7-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Church Cem. Upper Marlboro, Md.</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>Rollins Funeral Home, Inc. 4339 Hunt N.E.</b>		25a. RECD BY REGISTRAR <b>DATE JAN 6 1967</b>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**01256**

## CERTIFICATE OF DEATH

**01254**

<b>1 PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> MARYLAND				<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>17 days</b>		c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <b>Palmer Park</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>7608 Normandy Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Baby Boy Sudler</b>				<b>4 DATE OF DEATH</b> Month Day Year <b>Jan 9 19 67</b>			
<b>5. SEX</b> <b>Male</b>		<b>6 COLOR OR RACE</b> <b>Negro</b>		<b>7 MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8 DATE OF BIRTH</b> <b>23 Dec., 1966</b>	
<b>9 AGE</b> (In years lost birthday) yrs <b>17</b>		<b>10a USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Prince George's County Maryland</b>	
<b>12 CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				<b>13. FATHER'S NAME</b> <b>Augustus Brown</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Ella Sudler</b>				<b>15 WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)			
<b>16 SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> Address			

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>763.5</b> IMMEDIATE CAUSE (a) <u>pneumonitis</u> DUE TO (b) <u>prematurity (1100 gms)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>17 days</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>			
<b>20a ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		<b>20d INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f (City or town) (County) (State)</b>	
<b>21. I certify that (b) (this hospital) attended the deceased from Dec. 23, 19 66, to Jan. 9, 19 67, that (we) last saw the deceased alive on Jan. 9, 1967, and that death occurred at 10 AM, from causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> 		<b>22b. DATE SIGNED</b> <b>Jan. 10, 1967</b>	
<b>22c PHYSICIAN'S NAME</b> (Type) <b>Leroy E. Hoeck, M.D.</b>		<b>22d ADDRESS</b> <b>3611 Branch Ave., S.E. Hillcrest Hgts. Wash. D.C. 20023</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Cremation</b>		<b>23b. DATE THEREOF</b> <b>1/14/67</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Prince Georges Gen. Hosp. Cheverly PG Maryland</b>		<b>23d. LOCATION</b> (City or Town) (County) (State)	
<b>24. FUNERAL DIRECTOR</b> <b>Harry W. Penn, Jr., Admin., Cheverly, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE JAN 17 1967</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> 		<b>25c. REGISTRAR'S SIGNATURE</b> 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01257

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01255

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c LENGTH OF STAY IN 1b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chamber's Funeral Home		d STREET ADDRESS 2609 Nicholson Street	
3. NAME OF DECEASED (Type or print) First Middle Last Lamont C Swim		4. DATE OF DEATH Month Day Year 1 7 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 May 1941
9 AGE (In years last birthday) 25 yrs		10. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) ROUTE SALESMAN	
10b KIND OF BUSINESS OR INDUSTRY ROCK CR. BOTTLING CO		11 BIRTHPLACE (State or foreign country) CANADA	
12 CITIZEN OF WHAT COUNTRY? CANADA		13. FATHER'S NAME HAROLD SWIM	
14. MOTHER'S MAIDEN NAME EDITH THOMAS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv ce) NO	
16 SOCIAL SECURITY NO 577455513		17 INFORMANT MARGARET L. SWIM Address SAME AS #2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Drowning 929.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Drowned when boat capsized.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o'm 3:30pm p'm 12-26-1966		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work Potomac River Cove, mile so. of Wilson Br.	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, E.D. Riverdale, Md.		22. DATE SIGNED 1-9-67	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 10 JAN 1967	
23c NAME OF CEMETERY OR CREMATORY FORT LINCOLN		23d LOCATION (City or Town) (County) (State) BLADENSBURG MARYLAND	
24 FUNERAL DIRECTOR W. W. Chambers Co. Riverdale, Md.		25a REC'D BY REGISTRAR DATE JAN 13 1967	
25b REGISTRAR'S SIGNATURE J. Charles Judge			





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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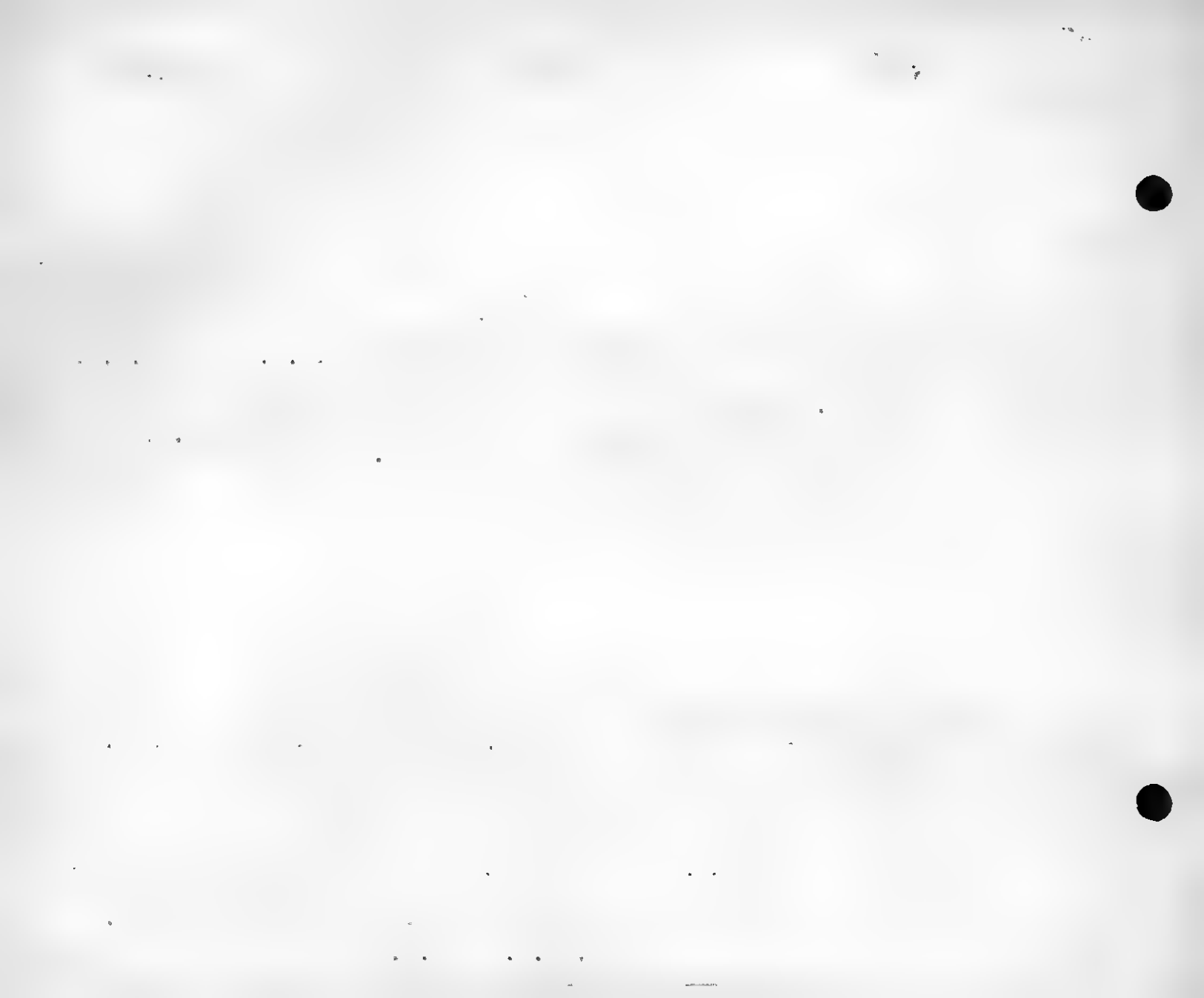
1  
M  
FOR STATE  
HEALTH DEPT.

01258

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01256

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e. STREET ADDRESS 4740 68th. Place		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Swope				4. DATE OF DEATH 1 9 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-2-1926		9. AGE (In years last birthday) 40 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George A. Swope				14. MOTHER'S MAIDEN NAME Virgie E. Bowman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 579326819		17. INFORMANT 2820- Erie St. S.E. Donald A. Swope-Bro.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain DUE TO Skull fractures Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)							INTERVAL BETWEEN ONSET AND DEATH 4 days
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Fell off bicycle					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 5:30pm 1-5- 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 67th. & Ingraham Sts., Riverdale, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 1-10-67		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-12-67		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City or town) (County) (State) Colmor Manor, Md.	
24. FUNERAL DIRECTOR Lee Funeral Home 300-4th St. N.E. Wash.				25a. REC'D BY REGISTRAR DATE JAN 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01257

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		d. STREET ADDRESS <b>5302 Hamilton Street, Apt. 5</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Estelle May Sykes</b>		4 DATE OF DEATH Month <b>1</b> Day <b>20</b> Year <b>19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1 March 1892</b>
9 AGE (In years lost birthday) <b>74</b> yrs		10 F UNDER 1 YEAR Months <b>1</b> Days <b>20</b> Hours <b>19</b> Min <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13 FATHER'S NAME <b>James N. Trail</b>		14 MOTHER'S MAIDEN NAME <b>—</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO <b>577 20 3617</b>	
17. INFORMANT <b>Wm C Trigger</b>		Address <b>Hyattsville, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>4200</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>unknown</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Osteomyelites of right tibia - over 20 years.</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of items 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>1-20-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 23, 1967</b>	
23c. NAME OF CEMETERY OR CREMATOR <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>	
24 FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 23 1967</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



01260

## CERTIFICATE OF DEATH

01258

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES'</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WANTHAM, MD.</b>		c. LENGTH OF STAY IN 1b <b>1 yrs 18 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MAGNOLIA GARDENS Nursing Home</b>		d. STREET ADDRESS <b>3421 - Newton St.</b>	
3. NAME OF DECEASED (Type or print) <b>DIANA MARY THOMAS</b>		4. DATE OF DEATH Month <b>JAN.</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/30/1886</b>
9. AGE (In years last birthday) <b>80-81</b> yrs.		10. IF UNDER 1 YEAR Months <b>27</b> Days <b>19</b> Hours <b>67</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>195-09-9909D</b>		16. SOCIAL SECURITY NO. <b>195-09-9909D</b>	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction - 5 min.</b> DUE TO (b) <b>4 min.</b> DUE TO (c) <b>5 min.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis (Coronary) 2 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12/9/65</b> , 19 <b>65</b> , to <b>1/27/67</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>26 Jan. 1967</b> , and that death occurred at <b>2:40 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Leon L. Lystachy</b>		22b. DATE SIGNED <b>1/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Leon L. Lystachy MD</b>		22d. ADDRESS <b>3408 R.F. Ave., Mt. Rainier, Md.</b>	
23a. BURIAL, CREMATION REMOVE (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>1/27/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Belmar Manor, Md.</b>
24. FUNERAL DIRECTOR <b>Valley's Funeral Home Inc.</b>		25. REC'D BY REGISTRAR <b>DATE JAN 30 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01261

## CERTIFICATE OF DEATH

01259

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE COUNTY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>P. G.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>			c. LENGTH OF STAY in lb <b>12 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOWIE MARYLAND</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>PRINCE GEORGE GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>4th. STREET, CHESTNUT AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>STACY L. THOMAS</b>				4. DATE OF DEATH <b>JANUARY 29 1967</b>		Day <b>29</b> Year <b>67</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-29-66</b>	
9. AGE (In years last birthday) <b>33</b> Yrs.				IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>19</b> Min		IF UNDER 24 HRS Hours <b>19</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Daniel Sharps</b>				14. MOTHER'S MAIDEN NAME <b>Patsy Thomas</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Miss Patsy Thomas</b> Address <b>4th St., Chestnut Ave, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chenionia</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 28, 1967</b> to <b>Jan. 29, 1967</b> that (I) (we) lost saw the deceased alive on <b>Jan. 29, 1967</b> , and that death occurred at <b>11:15 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				22b. DATE SIGNED <b>Jan. 30, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Bernardo Alvarado, M.D.</b>	
22d. ADDRESS <b>6201 Riverdale Rd. Riverdale, Md.</b>				22e. MED. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. DATE SIGNED <b>Jan. 30, 1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>2-4-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Cemetery Prince George county, Md.</b>		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR <b>John T. Rhines</b>				ADDRESS <b>3015 12th N. Bk.</b>		25. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
DATE <b>FEB 8 1967</b>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
01262					01260				
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-UPPER MARLBORO					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEARNEYSVILLE				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) JUNCTION OF CROOM STATION ROAD AND CROOMS ROAD, UPPER MARLBORO					d. STREET ADDRESS RT #1, BOX 133				
3. NAME OF DECEASED (Type or print) First Middle Last ANDREW JAMES TODD JR					4. DATE OF DEATH Month Day Year JANUARY 8 1967				
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 14 JAN 1932		9. AGE (In years last birthday) 34 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 2nd Class Petty Officer U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BISCOE, NORTH CAROLINA			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ANDREW JAMES TODD SR					14. MOTHER'S MAIDEN NAME MARIE ANTONETTE PATE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES					16. SOCIAL SECURITY NO. 51-55,57-59		17. INFORMANT Address OFFICIAL U. S. NAVY RECORDS		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INJURIES MULTIPLE EXTREME DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) AIRCRAFT ACCIDENT					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 11:07 a.m. 8 JAN 1967				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) FARM		20f. (City or town) (County) (State) NEAR UPPER MARLBORO, MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Kehoe					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) JOHN KEHOE, MD					22. DATE SIGNED 9 JAN 1967				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 1-12-1967		23c. NAME OF CEMETERY OR CREMATORY Masonic Cem.		23d. LOCATION (City, town or county) (State) CHARLESTOWN WEST, VA	
24. FUNERAL DIRECTOR W.W. Chambers Co 1400 Chapin St. N.W. Wash DC				25a. REC'D BY REGISTRAR DATE JAN 13 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

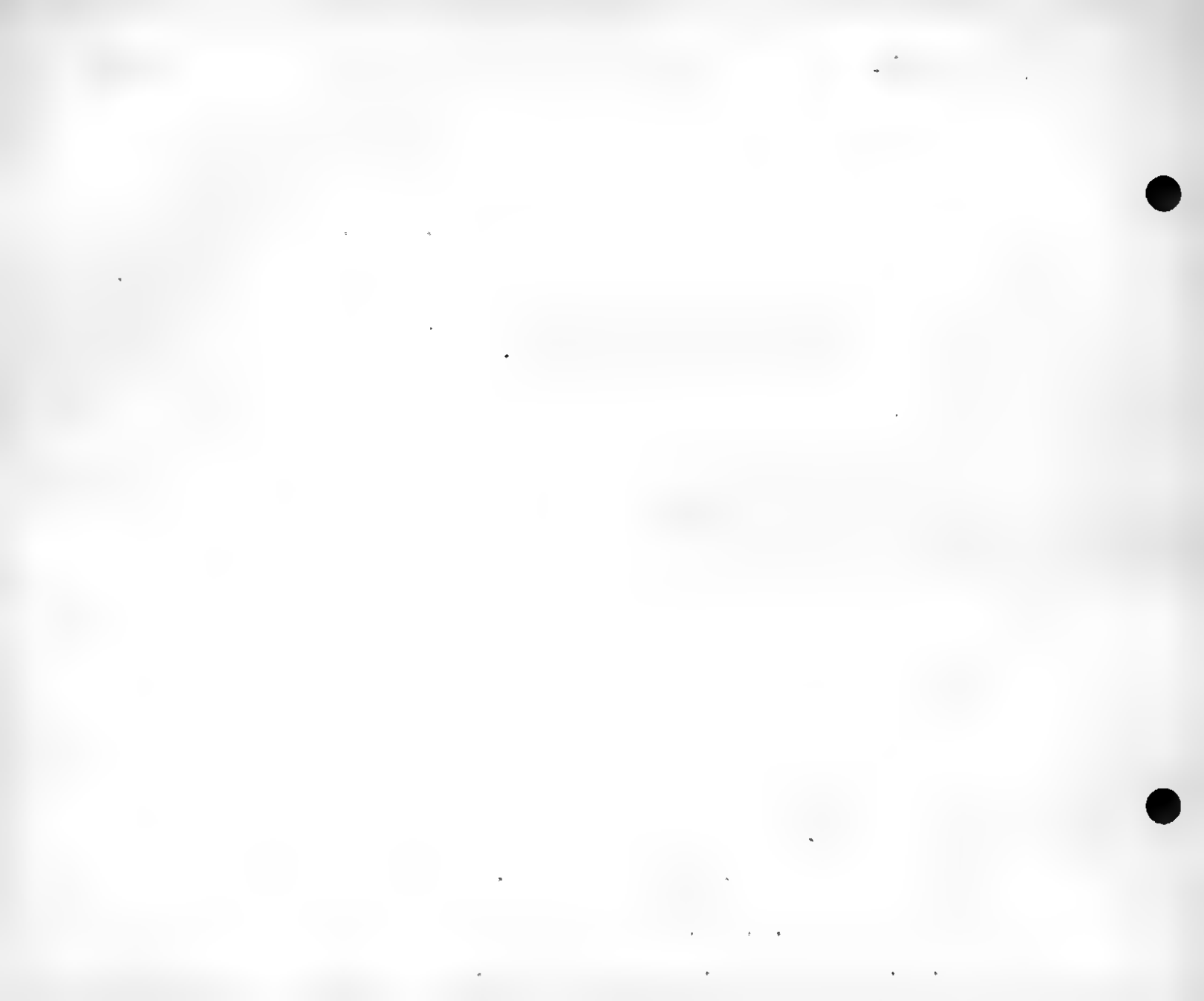
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01263

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01261

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>New York</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <b>First Aid Station, Bowie Race Track</b>		d. STREET ADDRESS <b>72 E. 123rd. Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Philip</b> Middle <b>Torocco</b> Last <b>Torocco</b>		4. DATE OF DEATH Month <b>1</b> Day <b>25</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>26 Feb. 1899</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Engine Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DEPT. HIGHWAYS NEW YORK CITY</b>	9 AGE (In years lost birthday) yrs. <b>67</b>
11 BIRTHPLACE (State or foreign country) <b>New York</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S</b>	
13. FATHER'S NAME <b>Unknown</b>		14 MOTHER'S MAIDEN NAME <b>Unknown</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. etc.) <b>No</b>		16 SOCIAL SECURITY NO <b>073 20 1736</b>	
17 INFORMANT <b>RALPH DABRACCIO</b>		Address <b>1210 BOWKE AVE BRONX, N.Y. 10469</b>	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart failure</b> 42000 DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>unknown</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus - known over 6 months</b>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county) <b>1-26-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 1, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>
24. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO., Riverdale, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 6 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01264

01262

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 hr. 20 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS Rt. 1 Box 371	
3 NAME OF DECEASED (Type or print) First Middle Last Roberta Ann Via			4 DATE OF DEATH Month Day Year 1 10 67		
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-0-1942	9 AGE (In years lost birthday) 24 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Fireman's Ins. Co		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Edna Mullin--Same item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock DUE TO (b) Rupture of right common iliac artery and vein (c) Multiple pelvic fractures					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Pedestrian struck by car.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 7:00am 1-10-1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Rt. 1, Box 371, Bowie, Md.	
20f. (City or town) Bowie		20g. (County) Prince George's		20h. (State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 1-10-67		22. DATE SIGNED	
EXAMINER'S NAME (Type) John Kehoe, I.D.		Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/13/67	23c. NAME OF CEMETERY OR CREMATORY Parkland		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR Lyon Wheeler Funeral Home Rockville, Maryland		25a. REC'D BY REGISTRAR JAN 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

01265

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01263

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-UPPER MARLBORO				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 30.4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) JUNCTION OF CROOM STATION ROAD AND CROOMS ROAD UPPER MARLBORO				d. STREET ADDRESS 5473 Cedonia Avenue			
3. NAME OF DECEASED (Type or print) First JAMES Middle FRANCIS Last VITAK				4. DATE OF DEATH Month JANUARY Day 8 Year 1967			
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 AUG 1930	9. AGE (In years last birthday) 36 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES JOSEPH VITAK				14. MOTHER'S MAIDEN NAME IDELLA JOSEPHINE GLACKEN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 218-22-1346		17. INFORMANT Address OFFICIAL U.S. NAVY RECORDS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INJURIES MULTIPLE EXTREME DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AIRCRAFT ACCIDENT					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1107 AM 8 JAN 1967		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) FARM		20f. (City or town) (County) (State) NEAR UPPER MARLBORO, MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JOHN KEHOE, MD				CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 9 JAN 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1-13-67		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION (City, town or county) (State) BALTO MD	
24. FUNERAL DIRECTOR W. H. ... Co Inc ... D.C.				25a. REC'D BY REGISTRAR DATE JAN 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

<div> <div>1</div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>01266</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>01264</div> </div> </div>									
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL-UPPER MARLBORO</b>					c. LENGTH OF STAY IN 1b 				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>JUNCTION OF CROOM STATION ROAD AND CROOMS ROAD, UPPER MARLBORO</b>					d. STREET ADDRESS <b>6707 RIVERDALE ROAD, APT # 1</b>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>FREDERICK FRANKLIN VREELAND JR</b>					4. DATE OF DEATH Month Day Year <b>JANUARY 8 19 67</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>6 OCT 1940</b>		9. AGE (In years last birthday) <b>26 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electronics Technician Naval Ordn. Lab.</b>		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>FREDERICK FRANKLIN VREELAND SR</b>					14. MOTHER'S MAIDEN NAME <b>MARY MANDALOV</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>					16. SOCIAL SECURITY NO. <b>218-38-8404</b>		17. INFORMANT <b>OFFICIAL U.S. NAVY RECORDS</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INJURIES MULTIPLE EXTREME</b> (b) <b>860X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>AIRCRAFT ACCIDENT</b>					
20c. TIME OF INJURY Month, Day, Year <b>1107 a.m. 8 JAN 19 67</b>				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>FARM</b>		20f. (City or town) (County) (State) <b>NEAR UPPER MARLBORO, MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>John Kehoe</b>					CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) <b>JOHN KEHOE, MD</b>					22. DATE SIGNED <b>9 JAN 1967</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Jan 16 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington, Va</b>		23d. LOCATION (City, town or county) (State) 	
24. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO. Silver Spring Md</b>						25a. REC'D BY REGISTRAR <b>JAN 16 1967</b>			
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



01267

CERTIFICATE OF DEATH

01265

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>8 hrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>8300 Freemont Street</b>	
3. NAME OF DECEASED (Type of print) <b>Lewis Ward Wagner</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>8</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>April 29, 1913</b>
9. AGE (In years last birthday) <b>53</b> yrs		IF UNDER 1 YEAR Months <b>8</b> Days <b>19</b> Hours <b>53</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dept of Agriculture</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U S Government</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Cass County Iowa</b>		12. CITIZENSHIP OF WHAT COUNTRY? <b>US A</b>	
13. FATHER'S NAME <b>Edward Wagner</b>		14. MOTHER'S MAIDEN NAME <b>Mary Woods</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>505 01 3721</b>	
17. INFORMANT <b>Mary June Wagner Carrollton, Md.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>451X</b> IMMEDIATE CAUSE (a) <b>Cardiac Tamponade</b> DUE TO (b) <b>Ruptured dissecting aneurysm of the aorta</b> DUE TO (c) <b>Atherosclerosis of the Aorta</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>8:45 PM 1/7/1967</b> to <b>1/8/1967</b> , that (1) (we) last saw the deceased alive on <b>1/8/1967</b> , and that death occurred at <b>4:40 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>William D Rosson MD</b>		22b. DATE SIGNED <b>1/8/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>William D Rosson M D</b>		22d. ADDRESS <b>5701 85th AVE, New Carrollton, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/11/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Massena Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Massena Cass Iowa</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 11 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

01268

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01266

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro, 16-1	
c. LENGTH OF STAY IN 1b 3 hrs.		d. STREET ADDRESS Maryland 20870	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Emory Wallace		4 DATE OF DEATH Month 1 Day 13 Year 19 67	
5 SEX M	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 May 1889
9. AGE (In years lost birthday) 77 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor	
11 BIRTHPLACE (State or foreign country) A.A. County, Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clay Wallace		14. MOTHER'S MAIDEN NAME Pricilla	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 220-28-6422	
17 INFORMANT Mrs. Mary E. Wallace-Upper Marlboro, /		Address Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Keefe, M.D., Riverdale		22. DATE SIGNED 1-14-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-18-67	
23c. NAME OF CEMETERY OR CREMATORY Moses Cemetery		23d. LOCATION (City or Town) (County) (State) Drury, A.A. Co., Md.	
24. FUNERAL DIRECTOR Leroy Berry		25a. REC'D BY REGISTRAR DATE JAN 17 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01269

CERTIFICATE OF DEATH

01267

1 PLACE OF DEATH a COUNTY <b>PRINCE GEORGE'S</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>MARYLAND</b>		b COUNTY <b>PRINCE GEORGE'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>		c LENGTH OF STAY IN 1b <b>1HR 4 MIN</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORRESTVILLE</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>		d STREET ADDRESS <b>3709 DONNELL DRIVE</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (type or print) First Middle Last <b>DANNY RUSSELL WARD</b>		4 DATE OF DEATH Month Day Year <b>10 JANUARY 19 67</b>			
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>CAUCASIAN</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10 JAN 67</b>	9 AGE (In years last birthday) yrs <b>1</b>	IF UNDER 1 YEAR Months Days <b>1 4</b>
10a LSLAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11 BIRTHPLACE (County & State, or foreign country) <b>PRINCE GEORGE'S, MD.</b>	
13 FATHER'S NAME <b>THOMAS RUSSELL WARD</b>		12. C TIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO N/A</b>		16 SOCIAL SECURITY NO <b>N/A</b>		17 INFORMANT Address <b>THOMAS R WARD-FATHER-SAME AS #2 ABOVE</b>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>7735 IMMEDIATE CAUSE (a) CARDIAC ARREST</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>PULMONARY FAILURE</b> DUE TO (c) <b>PREMATURITY</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 MIN</b>  <b>1HR 4MIN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>10 JAN</b> , 19 <b>67</b> , to <b>10 JAN</b> , 19 <b>67</b> , that <del>(X)</del> (we) last saw the deceased alive on <b>10 JAN</b> 19 <b>67</b> , and that death occurred at <b>9:40M</b> , from causes and on the date stated above.					
22a SIGNATURE <i>Arnold A. Abramo</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> A.M.		22b. DATE SIGNED <b>10 JAN 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARNOLD A ABRAMO, LT COL, USAF, MC</b>		22d. ADDRESS <b>USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331</b>			
23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <b>PUBLIC CREMATION</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <i>Carl F. Ousef</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JAN 30 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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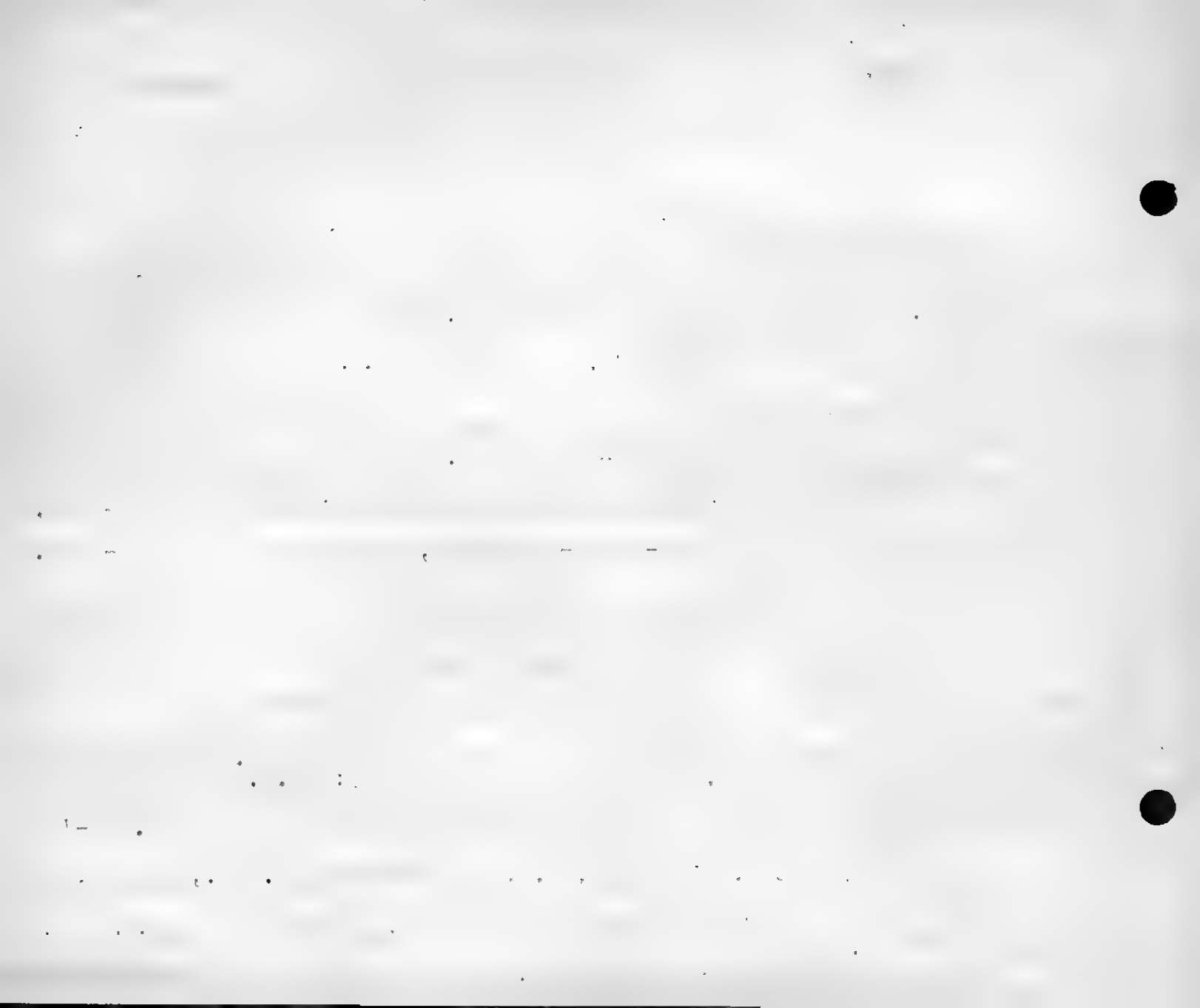
VR A15 (4)  
20 M 1/66

01270

CERTIFICATE OF DEATH

01268

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>			c. LENGTH OF STAY IN <b>16</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Odenton</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>				d. STREET ADDRESS <b>Odenton Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANNE NIVEN WARNER</b>				4. DATE OF DEATH Month <b>January</b> Day <b>10</b> Year <b>1967</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 15, 1916</b>		9. AGE (In years last birthday) <b>50</b> yrs		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Analyst</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Gov't.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Morven, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Carlton M. Niven</b>				14. MOTHER'S MAIDEN NAME <b>Isabella Niven Niven</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>256-36-5763</b>		17. INFORMANT <b>James C. Warner -son same as #2 above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Metastatic carcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cyst-Adeno-Carcinoma, Left Ovary</b> DUE TO (c) <b>None</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6-7 Mo.</b> <b>8-10 Mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1966</b> to <b>Jan. 10, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan. 9th 1967</b> , and that death occurred at <b>9:15 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <i>Robert C. Wingfield</i>				22b. DATE SIGNED <b>Jan.-10-'67</b>		22c. PHYSICIAN'S NAME (Type) <b>Robert C. Wingfield, M.D.</b>	
22d. ADDRESS <b>329 Prince Geo. St., Laurel, Md.</b>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/13/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Episcopal Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Odenton Anne Arundel Md.</b>	
24. FUNERAL DIRECTOR: <b>Hopping Funeral Home</b>				25a. REC'D BY REGISTRAR <b>JAN 16 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01269

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL-UPPER MARLBORO		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HYATTSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) JUNCTION OF CROOM STATION ROAD AND CROOMS ROAD, UPPER MARLBORO		d. STREET ADDRESS 2115 CHARLESTON PLACE	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK EUGENE WARNER		4. DATE OF DEATH Month Day Year JANUARY 8 1967	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 13 APR 1922
9. AGE (In years last birthday) 45 yrs.		10. IF FUNOER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LT CMDR		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK EDWARD WARNER		14. MOTHER'S MAIDEN NAME MAUDE ELLEN (UNKNOWN)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES 1961-1962		16. SOCIAL SECURITY NO. 577-24-5869	
17. INFORMANT OFFICIAL U.S. NAVY RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INJURIES MULTIPLE EXTREME Due TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AIRCRAFT ACCIDENT	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1107 8 JAN 19 67		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) FARM		20f. (City or town) (County) (State) NEAR UPPER MARLBORO, P.G. MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE JOHN KEHOE		22. DATE SIGNED 9 JAN 1967	
EXAMINER'S NAME (Type) JOHN KEHOE, MD		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-19-1967	
23c. NAME OF CEMETERY OR CREMATORY Columbia Heights		23d. LOCATION (City, town or county) (State) Ft. Meade, MD	
24. FUNERAL DIRECTOR W. C. C. ...		25a. REC'D BY REGISTRAR DATE JAN 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



# FOR STATE HEALTH DEPT.

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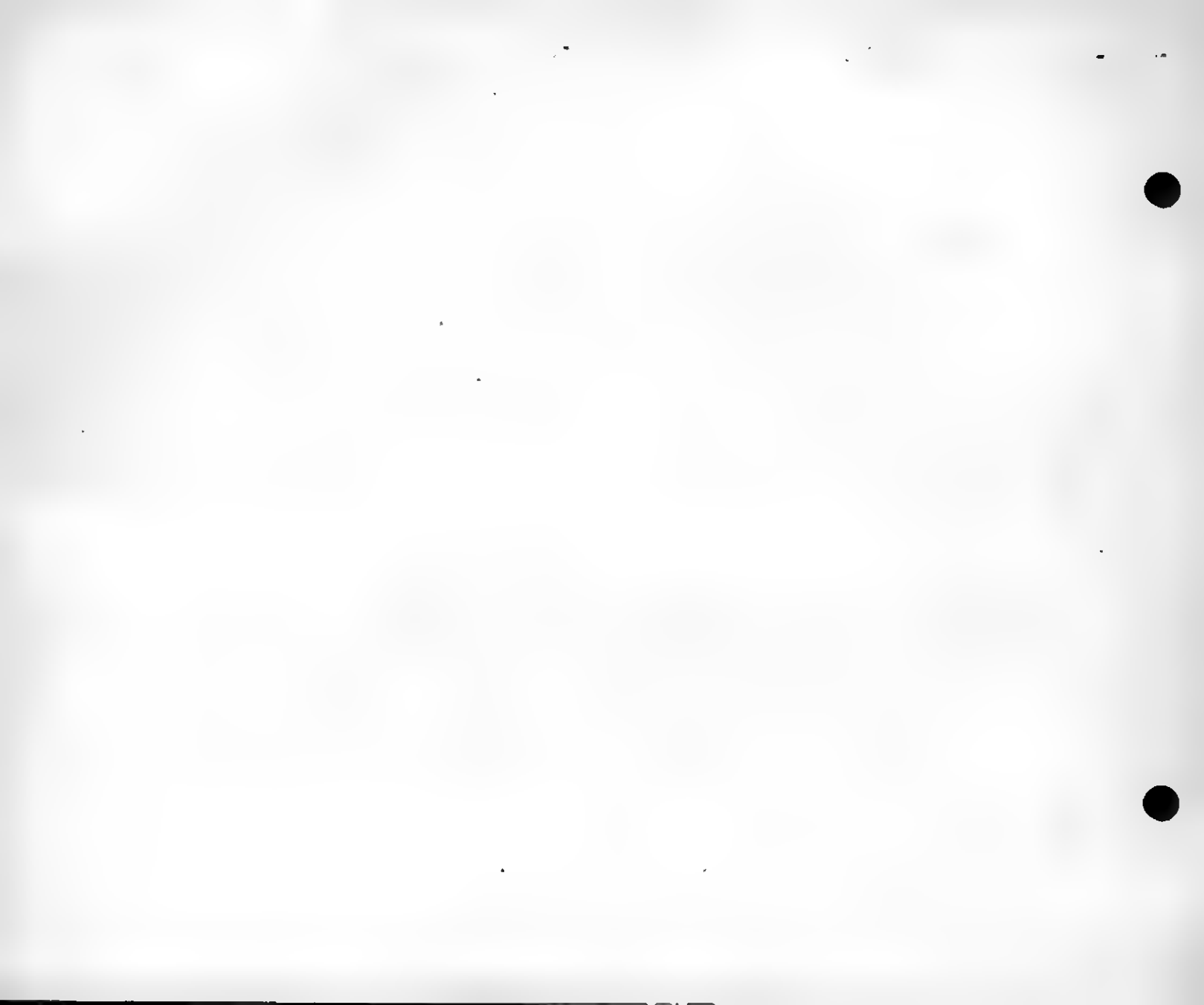
VR A15ME (5)  
6M 1/66

01272

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01270

1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Hillside</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>				d. STREET ADDRESS <u>1311 57th Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Lisa</u> Middle <u>Weldon</u> Last <u>Weldon</u>				4 DATE OF DEATH Month <u>1</u> Day <u>25</u> Year <u>1967</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>8 Nov. 1966</u>	9 AGE (in years last birthday) <u>1</u> yrs	IF UNDER 1 YEAR Months <u>2</u> Days <u>25</u> Hours <u>19</u> Min <u>67</u>		10 IF UNDER 24 HRS Hours <u>19</u> Min <u>67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Hannable E. Weldon</u>				14 MOTHER'S MIDDLE NAME <u>Laura</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO		17 INFORMANT <u>Hannable E. Weldon (Father)</u>		Address <u>1311-57th Ave Hillside, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c)) PART I DEATH WAS CAUSED BY <u>492X</u> IMMEDIATE CAUSE (a) <u>Pneumonitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>(SDII)</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe, M.D.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
John Kehoe, M.D. Riverdale, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22. DATE SIGNED <u>1-26-67</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1-31-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington Va.</u>	
24. FUNERAL DIRECTOR <u>Lafayette Funeral Home, 3831 Ga Ave, Wash DC</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01273

## CERTIFICATE OF DEATH

02660

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 3 hrs		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Farimont Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						d. STREET ADDRESS 6007 Lee Place					
3. NAME OF DECEASED (Type or print) Baby Boy Wellman						4. DATE OF DEATH Month Day Year Jan. 29 19 67					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 29 Jan., 1967		9. AGE (In years last birthday) yrs. 8		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Prince Georges, Md				12. CIT ZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Calvin Ernest Davis						14. MOTHER'S MAIDEN NAME Jeanette Wellman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>premature infant</i> DUE TO <i>apnea</i> (b) <i>asphyxia</i> DUE TO <i>cerebral anoxia</i> (c) <i>asphyxia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan. 29, 1967, to Jan. 29, 1967, that (I) (we) last saw the deceased alive on Jan. 29, 1967, and that death occurred at 8:15 PM, from causes and on the date stated above.											
22a. SIGNATURE <i>[Signature]</i>				22b. DATE SIGNED Jan. 30, 1967				22c. PHYSICIAN'S NAME (Type) Bernardo Alvarado, M.D.			
22d. ADDRESS 6201 Riverdale Rd. Riverdale, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 2/11/67		23c. NAME OF CEMETERY OR CREMATORY Prince Georges Gen. Hosp.		23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland			
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Maryland				25a. REC'D BY REGISTRAR DATE FEB 16 1967				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

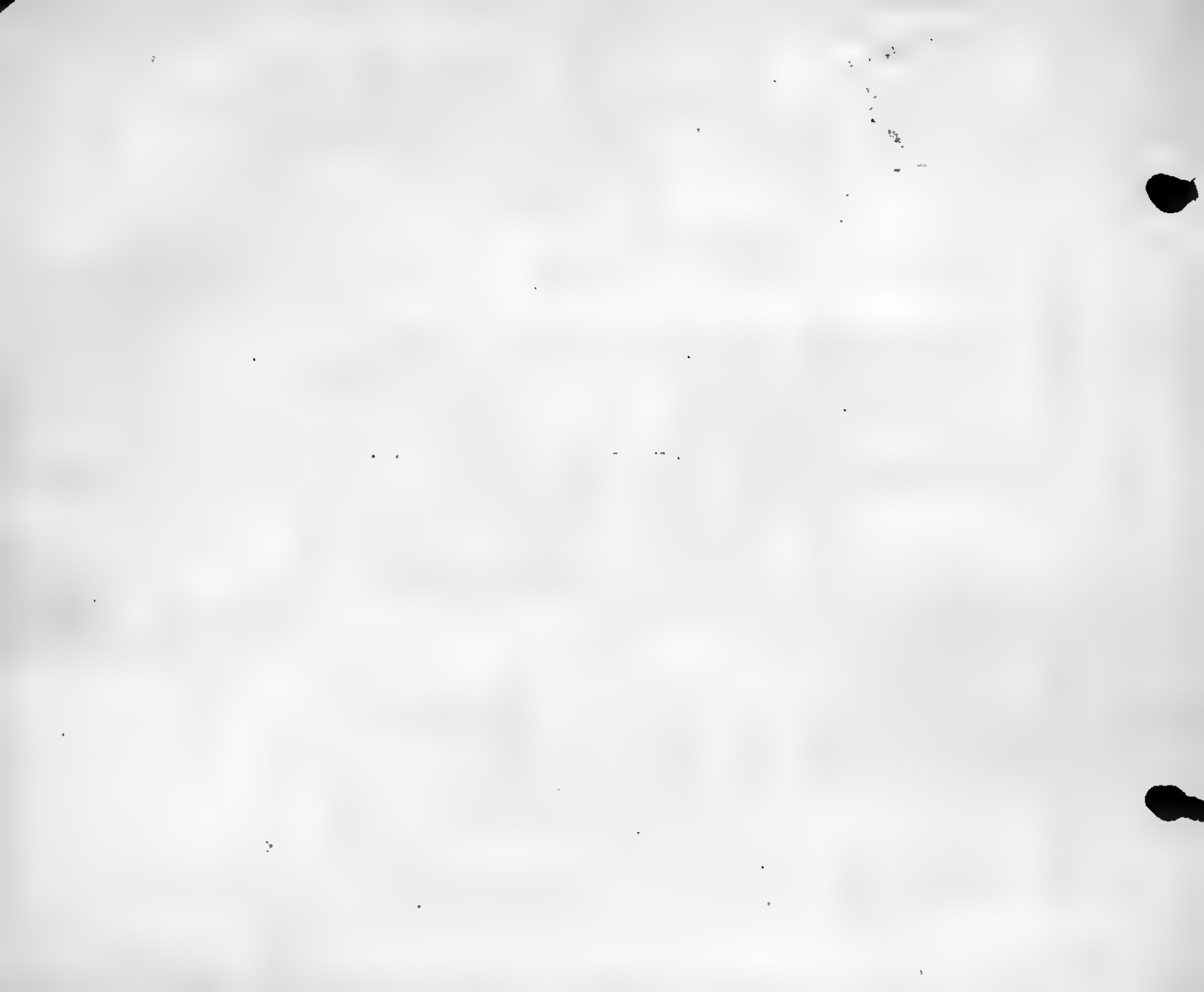
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

012774

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 012771

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - UPPER MARLBORO				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) PIKESVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) JUNCTION OF CROOM STATION ROAD AND CROOMS ROAD, UPPER MARLBORO				d. STREET ADDRESS 1320 SUDVALE ROAD			
3. NAME OF DECEASED (Type or print) First Middle Last STUART ALAN WERTZ				4. DATE OF DEATH Month Day Year JANUARY 8 1967			
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 13 JAN 43	
9. AGE (in years last birthday) 23 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DONALD EDWIN WERTZ				14. MOTHER'S MAIDEN NAME CAROLINE MAY WHEELER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES JUL 64-NOV 64				16. SOCIAL SECURITY NO. 220-429-117		17. INFORMANT OFFICIAL U.S. NAVY RECORDS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INJURIES MULTIPLE EXTREME Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AIRCRAFT ACCIDENT			
20c. TIME OF INJURY Month, Day, Year 1107 a.m. 8 JAN 19 67				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) FARM	
20f. (City or town) (County) (State) NEAR UPPER MARLBORO, MD.							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				22. DATE SIGNED 9 JAN 1967			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JOHN KEHOE, MD				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 1-13-67		23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEM	
23d. LOCATION (City, town or county) (State) BAGT MD							
24. FUNERAL DIRECTOR Wm. Chambers & 1400 Chapin St NW Wash D.C.				25a. REC'D BY REGISTRAR DATE JAN 13 1967			
25b. REGISTRAR'S SIGNATURE J Charles Judge							



1 (M)  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

31275

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01272

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>Prince George's</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c LENGTH OF STAY IN 1b <b>DOA</b>		2 USUAL RESIDENCE (Where deceased lived, if institution, on Res. before admission) a STATE <b>Maryland</b> b COUNTY <b>Prince George's</b> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenarden</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>1417 2nd. Street</b>	
3 NAME OF DECEASED (Type or print) <b>Fred</b>		4 DATE OF DEATH Month <b>1</b> Day <b>17</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>20 Jan. 1884</b>
9 AGE (In years, lost birthday) <b>82</b> yrs		10 IF UNDER 1 YEAR Months <b>1</b> Days <b>17</b> Hours <b>67</b> Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PICKERMAN</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Self</b>	
11. BIRTHPLACE (State or foreign country) <b>Smithfield, N.C.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>York.</b>		14. MOTHER'S MAIDEN NAME <b>York.</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>None</b>	
17 INFORMANT <b>Ruby Broadway - Daughter - Same as 2D</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>over 5 yrs.</b>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> pm	20d INJURY OCCURRED When <input type="checkbox"/> at work <input type="checkbox"/> While <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>		22. DATE SIGNED <b>1-18-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <b>1-21-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Elizabeth Ch. Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Lanham P.G. Co. Md.</b>
24. FUNERAL DIRECTOR <b>H.S. Washington &amp; Sons 4925 DEANE AVE NE</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 23 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-permit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01276

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01273

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3253 Queenstown Drive</b>		d. STREET ADDRESS <b>3253 Queenstown Drive</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Thomas Vincent Whalen</b>		4 DATE OF DEATH Month Day Year <b>January 13 1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 18, 1887</b>
9 AGE (In years last birthday) <b>79</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Thomas Whalen</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Atchinson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>217 32 1635A</b>	
17. INFORMANT <b>Louise W McLean</b>		Address <b>Mt Rainier, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <b>420.0</b> IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>unknown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF N. L. Y. Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city or town, county) <b>Arlington, Va</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>Jan 17, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 16 1967</b>	
Address <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



01277

## CERTIFICATE OF DEATH

Reg. Dist. No. 01274

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thantsville</u>			c. LENGTH OF STAY IN 1b <u>5 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor Nursing Home</u>				d. STREET ADDRESS <u>2021 R.I. Ave., N.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GUARDIANE (N.M.N.) WHITE</u>				4. DATE OF DEATH Month Day Year <u>Jan. 26 1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 4, 1888</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>London, Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emile Getzman</u>				14. MOTHER'S MAIDEN NAME <u>(UNKNOWN) Seigelman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>572-44-5322</u>		17. INFORMANT <u>Sister Christine, Carroll Manor Nursing Home</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Lymphocytic Leukemia</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 wks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced Arteriosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/30</u> , 19 <u>66</u> , to <u>1/26</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>1/26</u> , 19 <u>67</u> , and that death occurred at <u>12:55</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Steven Cristian M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>1534 16th St N.W. Wash. DC 1/26/67</u>					
PHYSICIAN'S NAME (Type) <u>Steven Cristian M.D.</u>							
22a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/28/67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVET CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS Co. RIVERDALE, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>Jan 30 1967</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01278

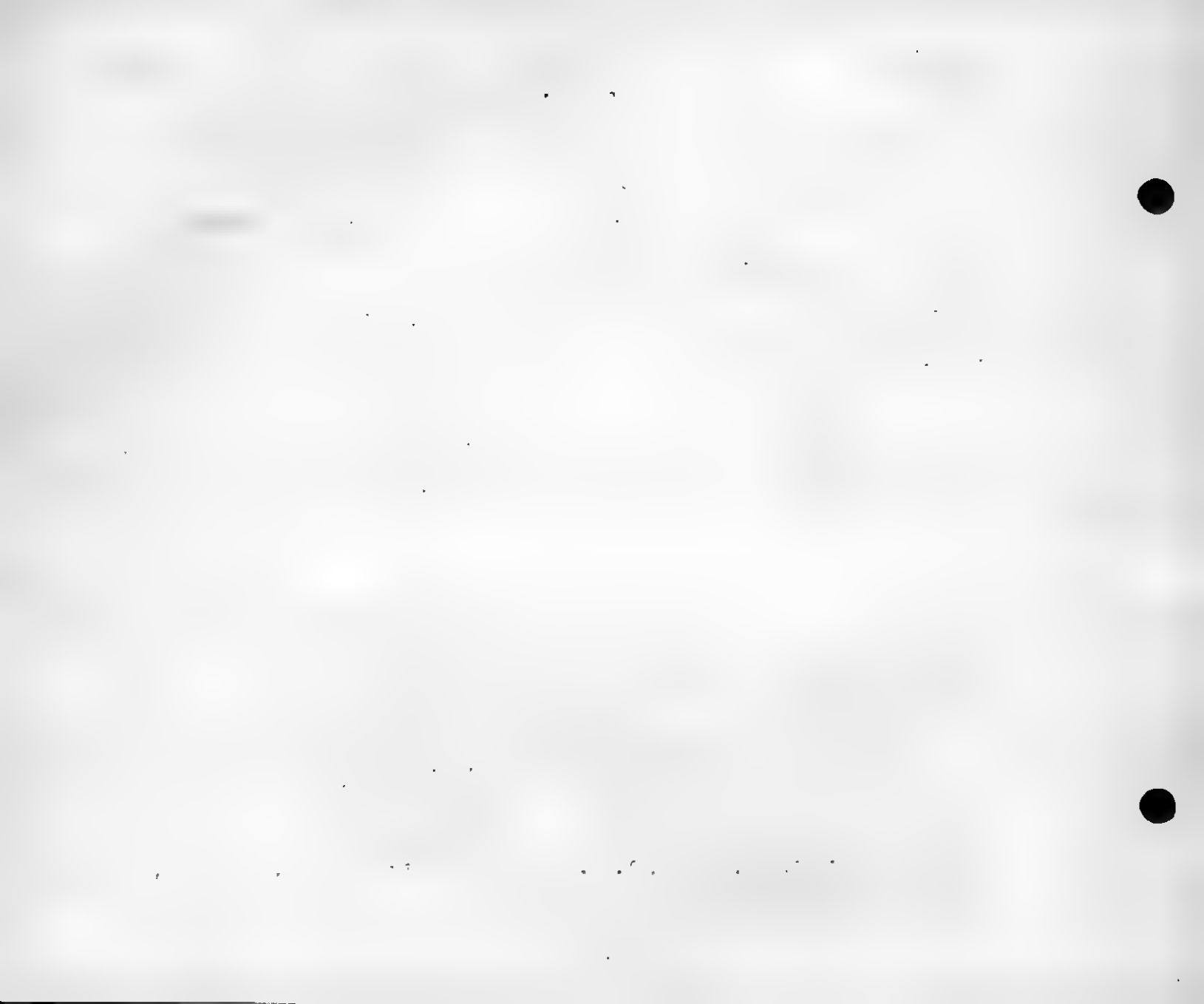
## CERTIFICATE OF DEATH

01275

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>6 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b> d. STREET ADDRESS <b>6705 McDonough Terrace</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marie Louise Wienecke</b>			4. DATE OF DEATH Month Day Year <b>Jan 31 19 67</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 Nov., 1912</b>	9. AGE (In years last birthday) <b>54</b> yrs	10. IF UNDER 1 YEAR Months Days Hours Min <b>19 67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13. FATHER'S NAME <b>Lebright Fritz</b>			14. MOTHER'S MAIDEN NAME <b>Louise</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>220 50 4352</b>	17. INFORMANT <b>Hospital records</b> Address <b>Cheverly, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hemorrhagic shock 2° GI bleeding etc.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>578X</b> (b) <b>Pulmonary embolism Bilateral multiple</b> (c) <b>Pulmonary edema - bilateral</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 25, 1967</b> , to <b>1-31, 1967</b> that (I) (we) last saw the deceased alive on <b>1-31, 1967</b> , and that death occurred at <b>6:00 AM</b> from causes and on the date stated above					
22a. SIGNATURE <b>William B. Hagan</b> M.D.			22b. DATESIGNED <b>1-31-67</b>		22c. PHYSICIAN'S NAME (Type) <b>William B. Hagan, M. D.</b>
22d. ADDRESS <b>6201 Riverdale Rd. Riverdale, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb 3, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	23d. LOCATION (City or Town)	(County)	(State)
			<b>Colmar Manor Pro Geo Md.</b>		
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>			ADDRESS <b>Hyattsville, Md.</b>		25. REG. BY REGISTRAR DATE <b>FEB 6 1967</b>
			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



01275

## CERTIFICATE OF DEATH

01276

1 PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>WASHINGTON D.C.</b> b. COUNTY <b>D.C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE MD</b>		c. LENGTH OF STAY IN 1b <b>9 YRS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON D.C.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CARROLL MANOR</b>				d. STREET ADDRESS <b>2430 PENN. AVE. N.W.</b>			
3 NAME OF DECEASED (Type or print) <b>LOUISE WILCOX</b>				4. DATE OF DEATH Month <b>1</b> Day <b>26</b> Year <b>1967</b>			
5 SEX <b>F</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-16-1879</b>		9 AGE (In years last birthday) yrs <b>87</b>	10 IF UNDER 1 YEAR Months <b>26</b> Days <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STENO-TYPIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GOVERNMENT</b>		11 BIRTHPLACE (County & State or foreign country) <b>FAIRFAX, VA.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WILLIAM D'NEAL WILCOX</b>				14. MOTHER'S MAIDEN NAME <b>MARY MANNING</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO WE</b>		17. INFORMANT <b>A. Jones</b> Address <b>CARROLL MANOR</b>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARTERIOSCLEROTIC HEART DISEASE</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs 10 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 12</b> , 1960, to <b>Jan 26</b> , 1967, that (I) (we) last saw the deceased alive on <b>1-24</b> 1967, and that death occurred at <b>2:30 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Thomas F. Collins</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1-26-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. COLLINS</b>				22d. ADDRESS <b>322-H 21 NE, WASH. D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-28-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington D. C.</b>	
24. FUNERAL DIRECTOR <b>J. F. Collins</b>				ADDRESS <b>Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>Jan 30 1967</b>	
FRANCIS J. COLLINS 3821 14th. St. N.W.				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

01280

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01277

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia b. COUNTY 83-1 ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 3338 Elm Terrace	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bowie Race Track Dispensary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Orion Oliver Wilson		4. DATE OF DEATH 1 7 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 1908 10 Nov. 1909 58 57 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Broker		11 BIRTHPLACE (State or foreign country) Cumberland, Md.	
10b. KIND OF BUSINESS OR INDUSTRY		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Orion O. Wilson		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16 SOCIAL SECURITY NO 214-07-1280	
17 INFORMANT Mrs. Millicent E. Wilson (above address)		18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) (a) Heart failure (b) Arteriosclerotic heart disease (c) over 5 yrs.	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 1-9-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		23b. DATE THEREOF 1/11/67	
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Va.	
24 FUNERAL DIRECTOR Nalley's Funeral Home Inc. Maryland		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE JAN 12 1967			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**01281**

## CERTIFICATE OF DEATH

**01278**

<b>1 PLACE OF DEATH</b> a. COUNTY <b>P.G.</b> <b>Riverdale</b> <small>MARYLAND</small>		<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>P.G.</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Riverdale,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Hospital,</b>		d. STREET ADDRESS <b>6128 Kenilworth Ave,</b>	
<b>3 NAME OF DECEASED</b> (Type or print) First <b>Florence</b> Middle <b>M</b> Last <b>Winters</b>		<b>4 DATE OF DEATH</b> Month <b>1-</b> Day <b>20</b> Year <b>19 67</b>	
<b>5 SEX</b> <b>Female</b>	<b>6 COLOR OR RACE</b> <b>White</b>	<b>7 MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8 DATE OF BIRTH</b> <b>3 Feb. 84</b>
<b>9 AGE</b> (In years last birthday) <b>82</b> yrs.		<b>10a USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife.</b>	
<b>10b KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11 BIRTHPLACE</b> (County & State, or foreign country) <b>Pa.</b>	
<b>12 CITIZEN OF WHAT COUNTRY?</b> <b>Amer</b>		<b>13 FATHER'S NAME</b> <b>Edward R. Boyer</b>	
<b>14 MOTHER'S MAIDEN NAME</b> <b>Lillie Reinhardt.</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, unknown) (If yes give war or dates of service) <b>None</b>	
<b>16 SOCIAL SECURITY NO</b> <b>220 26 6642</b>		<b>17 INFORMANT</b> <b>Eugene Leland Hospital</b> Address <b>4408 Queensbury Dr.</b> <b>Riverdale, Md.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>260X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>Diabetes</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1-10-67</b>			
<b>19 WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>20a ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	
<b>20d INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from 1-10, 1967 to 1-20, 1967, that (I) (we) lost saw the deceased alive on 1-20, 1967, and that death occurred at 1:30 P.M. from causes and on the date stated above.</b>	
<b>22a SIGNATURE</b> <b>George Hageage</b>		<b>22b. DATE SIGNED</b> <b>1-20-67</b>	
<b>22c PHYSICIAN'S NAME</b> (Type) <b>GEORGE HAGEAGE</b>		<b>22d. ADDRESS</b> <b>COTTAGE CITY MD.</b>	
<b>23a BURIAL, CREMATION REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>1/23/67</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Ft. Lincoln Cemetery</b>		<b>23d LOCATION</b> (City or Town) (County) (State) <b>Colmar Manor Md.</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Francis Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE JAN 23 1967</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						01279					
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham				16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital						d. STREET ADDRESS 7722 Frederick Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Richard Carol WINTERS						4. DATE OF DEATH Month Day Year 1 17 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 June 1960		9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY school		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Floyd Winters						14. MOTHER'S MAIDEN NAME Janette M Finley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. None		17. INFORMANT Henry C Johnson				Address Lanham, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 812.4 IMMEDIATE CAUSE (a) Laceration of brain DUE TO From multiple skull fractures Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by car.							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 1-17- 19 67 4:05pm				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) In front of 7726 Frederick Rd., Lanham, Md.				20f. (City or town) (County) P.G. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John Kehoe, M.D. Riverdale, Md.						22. DATE SIGNED 1-18-67					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Jan 20, 1967		23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City or Town) (County) (State) Arlington Virginia	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.						25a. REC'D BY REGISTRAR DATE JAN 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judy			

01310

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01283

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01280

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>		<u>1641</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>				d. STREET ADDRESS <u>1802 Metzgerott Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ober</u> <u>Agustus</u> <u>Witter</u>				4. DATE OF DEATH Month Day Year <u>1</u> <u>25</u> <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-28-1907</u>		9. AGE (In years lost birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar tender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mgr.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>XXXXXXXXXX ? Witter</u>				14. MOTHER'S MAIDEN NAME <u>Ada Berwager</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs. Helen V. Witter (above address- (Wife))</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>Rheumatic valvular heart disease with aortic stenosis and auricular fibrillation.</u> since childhood Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>stenosis and auricular fibrillation.</u> (c) <u>since childhood</u>							INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.				22. DATE SIGNED <u>1-26-67</u>			
EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u>				Address (Street, city, town, or county) <u>Riverdale, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>1/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR <u>Nalley's Home Inc.</u>				ADDRESS <u>Mt. Rainier, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 30 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

01280

01283

